Exploring the lived experience of obesity with people who have accessed NHS weight loss services

Claire Henry

Word count: 27,328

Submitted in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology to the University of East London, School of Psychology.

Acknowledgements

To Dr Kenneth Gannon and Dr Jacqueline Doyle for supervising this project and for providing support and encouragement along the way. This project would not have come into fruition without you, nor would it have been such an interesting and enriching experience without your guidance. Thank you both.

To the Obesity Empowerment Network, thank you for the wonderful work you do and for supporting me with recruitment. Most importantly, thank you to the participants of this study. Thank you for your openness and for trusting me with your stories. This project would not have been possible without you. I am ever grateful to you all.

To my parents for supporting me from day one. It has been very long journey since the day you dropped me off in Belfield to start university! Thank you for supporting me to follow my passion, even when it took me across the Irish sea.

Rebecca, Anna, Elaine, Lara, Alex, thank you for cheering me on through all the highs and lows, and for keeping me laughing all the way, you are all amazing!

Thank you to the women, who taught me to fight with determination and humor for what is right, and how to keep going in the darkest hours. You have all shown me that anything is possible. You know who you are.

Finally, to Chris for your patience and for weathering many storms with me over the past three years. Thank you for never doubting that I could do this.

Abstract

Background: Weight stigma poses a significant risk to the physical and psychological health of obese people (Puhl et al., 2018). A range of literature highlights that people regularly experience shame, humiliation, and rejection because of their weight. People defined as obese (BMI 30kg/m^2) see impacts on their identity, self-esteem, and mental health because of the internalisation of pervasive negative attitude to people classified as obese. Over the past number of years, we have seen increasing medicalisation of obesity. Currently, there is an on-going debate in the United Kingdom regarding whether obesity should be designated as a disease. While some argue that disease designation will reduce stigma and increase access to services (Widling, 2019), the British Psychological Society (BPS) suggest that obesity should be considered as arising as a result of a complex interplay of social, biological and psychological factors (BPS, 2019). People living with obesity must navigate these sometimes-conflicting ideas. This study seeks to explore the lived experience of obesity and the ways in which people who have accessed NHS weight loss services internalise and embody the dominant social ideas regarding obesity.

Method: This study adopted a phenomenological epistemological position. Eight semi-structured interviews were completed (eight women aged 38-71) with people who had accessed NHS weight loss services.

Results: Data was analysed using interpretative phenomenological analysis with a focus on the phenomenology of Merleau-Ponty and concepts of embodiment. Four key themes and eight sub-themes were identified. These include: The experience of a large body and the embodiment of the social construct of weight, making sense of weight gain, the social function of weight, and making sense of weight-based difficulties through dominant conceptualisations.

Conclusion: Weight stigma can become internalised to an extent that it significantly influences obese peoples' self-image and relationships. Obese people are acutely aware of the judgments that others make of them. They can feel that they fulfil a role in social groups, often holding others' anxieties about control and body size. People with obesity make sense of their weight through life experiences and events, however, it can be difficult to express nuance in a society that sees obesity as a moral or medical issue. Different

perspectives on the issue of obesity as a disease were expressed, however, there was a sense that disease designation could not adequately address the issue of weight stigma, which is the issue of utmost importance for participants in this study.

Contents

CHAPTER 1: INTRODUCTION

The ways in which people of a higher weight are viewed in society varies significantly throughout time and place (Vigarello, 2013). Throughout the seventeenth to nineteenth centuries, higher body weight was associated with prosperity and fertility (Ogden, 1992), highlighting a different view to the current negative attributions seen in western cultures. The idea that body size can determine health is not universally accepted (Mc Cullough & Hardin, 2013). In western nations, body weight is increasingly becoming a medicalised issue (Jutel, 2006; Wilding et al., 2019). In the context of medicalisation, higher body weight is problematised and is viewed as a risk to health. It is associated with increased risk of health problems such as type 2 diabetes, heart disease, and cancer (De Lorenzo et al., 2019). Individuals are encouraged to address the issue through lifestyle choices or medical intervention.

Maintaining a socially acceptable weight has come to be constructed as a moral issue. Associations between weight and morality are seen in the association of people with obesity as lazy, stupid, or undeserving (Jackson, 2016). Losing weight is often framed as a moral duty, a way to protect public services from unnecessary use by people who are deemed not to be complying with medical advice. Slimness has come to be associated with productivity and success (Webb, 2009), and obesity with poor economic productivity (OECD, 2019).

The "war on obesity" is commonly used to frame the aim of reducing the prevalence of obesity in society, in which obesity is seen as a threat to social order and values. It also represents the centering of weight focused accounts of health (O'Hara & Taylor, 2018), where the "war" must be won to restore the health of people and society. It is often stated that we face an "epidemic of obesity" (Jaacks et al., 2019). This term may represent the levels of moral anxiety existing around obesity (Flegal, 2005). The use of the term "epidemic" is widely used in the literature, despite the lack of clarity on whether obesity meets the criteria of an epidemic (Flegal, 2005). The choice to describe obesity in this way, may in part be a social metaphor for the levels of fear existing around it (Flegal, 2005) with

the medicalisation and individualisation of health further promoting the moral panic surrounding obesity (Boero, 2007).

While medicalised understandings of weight problems are dominant, research shows that people draw on a multitude of ways of making sense of their weight (as will be explored in detail on page 6)**.** Therefore, it is important to consider the way in which language is used as this has the power to position the issue in particular ways. Medicalised understandings of weight are dominant in the UK, with "obesity" being the preferred term. Obesity is a medical term used to describe people wo are defined as having a Body Mass Index (BMI) of 30kg/m^2 or greater. While obesity is a descriptor label for what is deemed to be excess body weight, it often carries negative connotations and associations of judgement.

For the purposes of this project non-pathologising language in relation to body weight will be used where possible. This approach has been taken as it is in keeping with the phenomenological epistemological position of this thesis and may be less likely to hold negative or moral connotations. However, excess body weight is deeply stigmatised, both aesthetically and through language, thus choices of terminology are unlikely to fully reduce the stigma experienced. It will at times be necessary to use medicalised terms, as this reflects the language used in much of the literature. The participants in this study varied in their choice of language. This reflects the many ways in which people make sense of obesity, their personal experiences, and the contact they have had with services and professionals.

1.1 Epidemiological considerations

Engaging with epidemiological data situates why obesity has become an area of concern for public health. Medical definitions are widely used in epidemiological research in relation to body weight. This has served to inform how higher body weight is thought about societally, as well as the ways in which it is responded to in a public health context. BMI is used to understand prevalence of obesity in society and data tends to demonstrate that prevalence is increasing, giving rise to concern from governments, public health bodies and third sector organizations. In the UK 27% of adults are defined as obese (Body Mass Index [BMI] 30kg/m-^{2} or greater). Additionally, 41% of men and 37% of women are deemed to be overweight (BMI 25kg/m^2 to 30kg/m^2) (Keaver & Webber, 2016). Prevalence of obesity is thought to be

increasing. By 2035 it is anticipated that 8% of people living in England will meet criteria for morbid obesity (BMI 40kg/m^2). While BMI is widely used, it has been subject to critique. Some research has highlighted that a BMI in the overweight range correlates with a low risk of mortality (Afzal et al., 2016), suggesting increases in weight may not have the assumed linear relationship with poor health. There are also ethic differences in percentage adiposity and BMI between ethnic groups. With obesity related morbidity occurring at a lower BMI among South Asian people relative to white people (Kanaya et al., 2014). This raises concerns about racial bias inherent in the BMI system.

Across the UK it is forecast that 5 million people will meet the criteria for morbid obesity by 2035 (Keaver & Webber, 2016). There has also been an upward trend in childhood obesity. In the year 2018-2019 the child measurement program found that in reception year 9.7% of children were obese an increase of 0.2% from the previous year (Public Health England & NHS Digital, 2019).

The rise in obesity is associated with higher costs to the NHS. In 2014-2015 the NHS spent £6.1 billion on overweight and obesity related ill-health (Public Health England, 2017). Obesity is considered to increase the risk of cardiovascular diseases; mainly heart disease and stroke, diabetes, some cancers, and musculoskeletal disorders, for example, osteoarthritis (World Health Organization, 2020). Costs to the NHS may go some way towards explaining the why obesity has come to be moralised. If obesity is constructed as either a personal choice or due to a failure to comply with medical advice or treatment (Brownell et al., 2010), then people come to be seen as willfully negligent towards their health, thus costing the tax payer significant sums of money.

There is a well-established relationship between obesity and social deprivation. In the most deprived areas of the UK 40% of children are overweight or obese. This reduces to 27% in the most affluent areas (Royal College of Pediatrics and Child Health, 2017). Among children of lower socioeconomic status, factors such as no access to a playground, not eating breakfast daily, less fruit consumption and more time spent watching TV are associated with higher weight (Goisis et al., 2015). In adult populations increases in obesity are often associated with high availability of cheap high energy food, unemployment, lower educational level, lack of resources and lack of access to sports and recreation. Areas with

high levels of poverty often suffer from a lack of access to fresh, healthy, high quality food. (Drewnowski & Specter, 2004; Żukiewicz-Sobczak et al., 2014). This link underlies the need for researchers to think beyond moral and medical ideas concerning obesity and to look towards the complexity of peoples' experiences, relationships, social circumstances, and psychological health. If obesity disproportionally effects people experiencing social deprivation, then moralising and stigmaising attitudes are likely to perpetuate already existing inequalities, such as racism or classism. Therefore, it is important that we seek to understand the experiences of people who have difficulties with their weight, and the impact that increasing medicalisation has.

1.2 Interventions for Obesity

Medical interventions have the stated aim of helping people to reduce their BMI and thus, reduce the risk of other health complications associated with obesity. The National Institute for Clinical Excellence (NICE) (2014), outline recommendations for the treatment of obesity. Access to weight management programs which include behaviour modification are recommended in addition to an increase in physical activity. Pharmacological interventions are offered when dietary and physical activity programs are deemed to have failed. Bariatric surgery is offered when specific criteria are met, such as a BMI of over 35/m^2. Bariatric surgery is associated with significant weight loss that is maintained over a long-term period. Outcomes also include improvements in type 2 diabetes, hypertension, stroke and heart attack (Douglas et al., 2015).This guidance points to the way in which difficulties with weight are increasingly considered to be an issue that should be resolved though medical intervention.

Obesity is an area of increasing interest for Clinical Psychology in the UK. The British Psychological Society (BPS) emphasise that psychologists can play a multi-faceted role in obesity. This encompasses service provision in NHS weight management services, as well as research, policy development and influencing understandings of obesity at a societal level (BPS, 2019). In promoting a biopsychosocial approach to obesity, the BPS outline how a psychologically informed approach to understanding, preventing, and treating obesity can be offered. Psychologists should also play a role in the reduction of obesity stigma (BPS,

2019). The effects of obesity stigma are well documented an include an increased risk of further weight gain, weight cycling, poor engagement with health services and poor mental health outcomes (Puhl & Heuer, 2010; Puhl & Suh, 2015; Tomiyama et al., 2018).

Psychologists are an essential part of a multi-disciplinary Bariatric surgery team (BOMMS, 2019). Their role in a Bariatric MDT is to support with pre-surgery assessment and support in preparing for the psycho-social impacts of surgery. They also provide post-surgery support for issues such as weight-regain, adapting to the impacts of surgery and issues with body-image (BOMMS, 2019). Psychological assessment and formulation are key in understanding the host of complex psychological and social factors that lead to maintenance of unhelpful eating behaviors. Without this understanding and support, medical interventions such as surgery may be less successful (BPS, 2019).

1.3 Literature Review

1.3.1 Scoping review

A scoping review was completed in the data search stage of this project. Scoping reviews are deemed to be helpful in determining the range of evidence informing practice and policy in a field as well as identifying gaps in the research literature (Peters et al., 2015).

The scoping review began with an initial search of the literature to identify key areas and issues. This supported the development of pertinent search terms (Appendix A) which were then used. Databases used in the literature search included: PsychInfo, PsychArticles, Scopus, CINAHL, PubMed, academic search complete and google scholar. Reference sections of papers were also scanned to help identify relevant papers.

Obesity is an area that draws significant research interest across several fields. The initial search yielded 5,124 articles. Many of these articles were not relevant to clinical psychology or this study and were, for example, medical and surgical in nature. The search terms: “obesity” and “disease”, which were necessary for this study, produced high numbers of non-relevant articles, for example, medical articles concerning obesity risk factors. It was

not possible to fully engage with all articles found due to practical and time constraints; therefore, steps were taken to make the search more manageable. Inclusion and exclusion criteria helped to narrow the search (Appendix A). Articles that met the inclusion criteria were read in full. Duplicates were removed. In the end 101 articles that met inclusion criteria were utilised.

1.4 Lived Experiences

Work capturing the experiences of people with obesity has highlighted the way in which experience is informed by the social and cultural context. In Western cultural contexts, weight stigma is pervasive. Studies exploring the experiences of obesity consistently find that people experience shame, disgust, and self-hatred in relation to their weight. This causes significant psychological distress (Furber & McGowan, 2011; Merrill & Grassley, 2008; Ogden & Clementi, 2010). Studies suggest that obesity does not solely have a negative emotional response to their self-image, but their sense of identity is influenced by their weight (Ratcliffe & Ellison, 2015). The reasons for this seem to be due to their experiences of stigma in society and exposure to it over prolonged periods of time.

A study examining the experiences of pregnant woman with obesity found that women often experienced humiliation throughout the course of their pregnancy. This often occurred in healthcare settings, for example, when undergoing routine scans (Furber & McGowan, 2011). Pregnant women with obesity were not only problematised, but they were also medicalised in healthcare settings. Deemed to be high-risk, they were told their babies would be larger than average, although this rarely materalised. Women reported feeling that their safety was secondary to that of their unborn baby, highlighting the struggle woman felt to be treated with dignity and respect. The stigmatised attitudes of healthcare professionals were explicit and strongly felt by the women, with their BMI a central feature of how they were treated and discussed by the professionals caring for them (Furber & McGowan, 2011). This study highlights the inescapability of weight-based stigma encountered by people in all aspects of their medical care.

In examining the lived experiences of overweight women patients in their encounters with healthcare services (Merrill & Grassley, 2008) highlighted that women often experience exclusion due to the physical environment of the clinic. Seating, waiting areas and equipment were unsuitable for people of a larger size, leading to feelings of dread about accessing healthcare services. This led to a hypervigilance and anxiety about being in these settings, which are not designed for or inclusive of their needs. In engaging with healthcare professions women were often encouraged to lose weight to improve their health conditions, these suggestions were experienced as dismissive and overly simplistic (Merrill & Grassley, 2008).

Tischner, (2012) suggests that there may be a gendered aspect to the adoption of weight as an identity; for women negative perceptions of their body become internalised and begin to inform their sense of identity. For women, the body is an expression of femininity, and a larger body is de-feminised and de-sexualised. Larger women are acutely aware of the judgment others make about them based on their size. They respond to this through self-surveillance and trying to make themselves and their bodies acceptable to others (Westland, 2016). Women may internalise the perceptions of others, and despite their struggles against these ideas, they become part of how they view themselves, igniting feelings of self-consciousness and shame. One's weight can also become integrated into their sense of self through the on-going attempts to manage or control weight. This leads to weight becoming all-consuming in a number of ways, for example, mentally and financially (Merrill & Grassley, 2008).

Being deemed to be obese can impact mood and self-esteem. Participants in a study by Ogden and Clementi (2010) expressed that due to their weight, they felt miserable, guilty, angry, and sometimes suicidal. The way in which weight is incorporated into participants' self-identity was also reflected in difficulties adjusting to having lost weight. One participant commented that they still see themselves as over-weight when they look in the mirror, and still felt they needed to buy larger clothes, despite being significantly smaller (Ogden & Clementi, 2010). The study also examined the role that food played in participants lives. People spoke about the cultural, family, and relational aspects of food which were important to them and their sense of identity. Food also served as a tool for emotion regulation, with some participants likening their difficulties with food to being an alcoholic.

Food becomes something that is relied upon for soothing and thus it is difficult to move away from this, it becomes an addition of sorts (Ogden & Clementi, 2010). The above highlights the complexity of peoples' experiences, demonstrating that weight and attempts to lose it are not a simple case of choosing to eat less. In fact, persistent attempts to lose weight, resulting in initial weight loss, followed by re-gain and stagnation may explain the distress experienced by people with obesity (Bombak & Monaghan, 2017). Therefore, it is not sufficient to state that obesity results in psychological distress. Stigma, and pressure to lose weight, including the negative consequences of engaging in weight loss attempts must be considered when looking at the links between obesity and psychological health.

For some, the experience of obesity is living with a sense that one's life is on hold (Haga et al., 2020). Having a larger body is a barrier to many of life's goals. People wait for a time when they are slimmer so they can live their desired lives, feeling that because they do not have a slim body, they cannot have a normal life. A sense of putting life on hold extends beyond activities and into relationships. Single people stated that they would put off dating due to shyness or shame felt about their body (Haga et al., 2020). These findings suggest that having a larger body leads to experiences of exclusion and otherness, impacting on the development of intimate relationships.

For people deemed to be overweight, there is a pressure pursue a thin aesthetic. This seems to be a taken for granted reality for many people. An Australian study found that larger people may spend many years attempting to lose weight. This was also the case among people who did not view their weight as problematic (Thomas et al., 2008). This highlights the pervasiveness of the expectation to have a thin body and a sense of duty people feel to engage with dieting and weight loss, even when their weight it acceptable to themselves. (Bombak & Monaghan, 2017) found that some obese people who reported previous eating disorders may oscillate between wanting to lose weight and campaigning for movements that promote that health is not defined by weight. Overall, however, people expressed a hope that at some future point they would meet normative weight expectations. This highlights that despite best efforts to engage critically with ideas about thinness, sense of need to lose weight is extremely powerful.

Ogden (1992) highlights that the pursuit of weight loss through dieting is about more than seeking a smaller body. Thinness is associated with control, the ability to resist impulses and with being psychologically stable. These very powerful associations demonstrate why the pursuit of a smaller body becomes a compelling focus for people. Thin gives status and acceptance. Research exploring people's attempts to lose weight has found the psychological demands associated with maintaining a weight loss programme. This requires sustained mental effort and organisation which may not be possible. Others spoke of social pressure as a result of feeling alienated from social groups due to their weight loss behaviors, for example, avoiding certain foods (Rogerson et al., 2016). The prevailing assumption that weight loss is positive for a person's health neglects the harm that repeated attempts to engage in weight loss can have. Chronic dieting can have implications for both physical and mental health as well as having a profound impact on people's relationship to food. Certain food items become value laden, they may be viewed as "forbidden" or "bad" and their consumption lead to feelings of failure and the need to compensate for such a failure. Chronic dieting can result in disorder eating patterns, whereby people stop knowing what it is to eat normally and nourish one's body as it needs (Carryer, 2001).

Larger bodies are objectified, and the embodied experience can be one of disownment. In a study by (Ueland et al., 2019, p.16) larger bodies became "bodily objects" where people concealed part of themselves, for example, their stomach or avoided photographs, particularly full body photographs. The authors conclude that objectification of larger bodies is linked to the internalisation of weight-stigma and cultural preferences for slimness.

For many people, the lived experience of obesity is of exclusion. This includes when people engage in practices thought to help them reduce their body weight. Obese people using gym spaces report feeling excluded, as though they do not belong, and a sense of otherness (Thomas et al., 2008). This study suggests that there may be an embodied experience of otherness which is experienced by obese people, acting as a barrier to accessing health promoting environments such as gyms. Other barriers to physical activity include pain when exercising, for example joint pain and breathlessness (Danielsen et al., 2015).

People living with obesity draw on wide ranging ideas about obesity causation. A study of people undergoing bariatric surgery found that people largely saw weight and eating as something that was out of their control. Hereditary explanations of weight were frequently drawn upon and participants positioned themselves passively in relation to obesity (da Silva & da Costa Maia, 2012). In a study with people living in Australia, participants attributed the high price of healthy food, accessibility of cheap high calorie food, lack of support and genetic factors that may increase some people's likelihood of gaining weight.

In an exploration of existential experiences of obesity, (Ueland et al., 2019) highlighted that participant's difficulties with food began at an early age and were able to identify the precise time that food and eating became a problem. Food and eating were rooted in the relational dynamics of the family, such as rules about eating, a lack of emotional intimacy in the family and experiences of rejection. Participants in this study also expressed that they felt trapped by food. They felt that they could not live the life they wanted because of their size. They also struggled to understand themselves, with various eating disorder diagnoses not fitting with their experiences. This study demonstrates that people who have problems with their weight, are aware of where their difficulties originate and that these problems may be rooted in early relational experiences. The study also highlighted shortcomings with medicalised understandings of problems with eating and food which may not fully account for the complexity of people's experiences.

1.5 Weight stigma, internalisation, and health

The cyclic obesity/weight-based stigma (COBWEBS) model (Tomiyama, 2014) provides an integrated, biopsychosocial approach to weight stigma. The model posits that weight stigma leads to harmful behavioural, emotional, and physiological responses. This then increases the risk of weight gain. Entry to the cycle is not determined by a person's weight, but rather on their sense of stigmatisation. The model states that a person can leave the cycle in one of the following ways, the person changes their view of their weight, reaching the upper limit of their body weight, or through weight loss and maintenance. The COBWEBS model highlights that repetitive weight gain occurs by becoming locked in the cycle. It also provides

a representation for how weight stigma poses a direct threat to health. A critique of the model is that it fails to represent the ways in which social structures may influence stigmatisation as these may change over time.

Weight stigma continues to increase in society and poses a threat to the health of people of a higher weight (Brandsma, 2005; Puhl & Suh, 2015; Tomiyama et al., 2018). Weight stigmatisation is associated with poor health outcomes relating to behavioral and psychological outcomes. Disordered eating, weight cycling, poor body-image, depression, exercise avoidance are well documented effects of weight bias (Brewis et al., 2018; Puhl & Heuer, 2010). While the societal discourse regarding obesity is heavily focused on obesity as a public health issue, some researchers are beginning to identify weight stigma as and its psychosomatic influences as a significant public health issue in itself (Oli Williams & Ellen Annandale, 2019).

Weight bias internalisation refers to the internalisation of negative stereotypes and subsequent self-disparagement (Pearl & Puhl, 2018). People may become highly self-critical or begin to believe they are lazy or undesirable. People who exhibit internalised weight bias experience higher levels of depression, anxiety and disordered eating compared to people of a similar weight who do not exhibit internalised weight bias (Puhl et al., 2018; Schvey et al., 2013). This finding is important as it suggests that it is not simply the presence of weight-based stigma that causes adverse experiences, but that when stigamtised views are internalised and embodied by the person, they then begin to cause problems. Internalisation of stigma also impacts on peoples' experience of their bodies, its appearance, and sensations. The moral association of weight leads people to experience a sense of having been "bad" or "heavy". This can exist even though "feeling heavy" does not always translate to having gained weight (Williams & Annandale, 2018).

Strategies that defy dominant stigmatising and discriminatory discourses surrounding weight can be seen in peoples' rejections of medical definitions of overweight, where people reflect on the nuances of weight, health, and fitness, rather than having these shaped by BMI. However, there is a sense that credibility could be added to one's position of resistance to weight stigma by announcing oneself to be a "normal weight" (De Brún et

al., 2014). Indeed, overweight has come to be associated with a lack of credibility, stupidity, and laziness (Puhl & Brownell, 2001).

There is limited research regarding what increasing medicalisation may have on people who use weight loss services and their experience of weight stigma. Some research has indicated that under disease classification body image satisfaction improves, but there is a tendency towards higher calorie food choices. Thus, this may reduce the likelihood that people will engage in self-regulatory behaviours for obesity management (Hoyt et al., 2014). This conclusion demonstrates the privileging of individual responsibility in terms of managing weight and a concern that disease classification of obesity might give people a sense that they do not need to take responsibility for their behaviour.

1.6 Understanding Obesity

As highlighted, medicalised understandings of obesity are becoming increasingly dominant. This section will discuss approaches to understanding obesity, considering increasing medicalisation and on-going debates.

1.6.1 Systems Based Approaches to Obesity

The Foresight report (Government Office for Science, 2007) demonstrates the complex interaction between individual, behavioural, biological, societal, and economic interactions which contribute to rising obesity levels in a society. While complex, the systems map is important as it visually represents the level of complexity present in this issue and provides a multi-faceted systems approach to understanding obesity. This promotes policy responses to think beyond the individual and behavioural. The system demonstrates a dynamic feedback loop, locking people into energy imbalance at an individual and societal level. It is interesting to note the disparity in understandings of obesity between the Foresight report and the dominant medicalised ideas. This map highlights that obesity is not simply a medical issue but is intertwined with politics inequalities and social policy and economic decisions.

1.6.2 Obesogenic Environments

The ANGELO framework categorizes all societal and environmental drivers of obesity across the four domains of; physical, economic, legislative, and socio-cultural environments (Swinburn et al., 1999). Links between micro-environments (for example a supermarket) and macro environments (for example, food industry) interact to develop an environment that is obesogenic. Policy, infrastructure, industry, and political systems impact greatly on daily life and how an environment grows and sustains itself. When the macro system does not enable healthy lifestyles at the micro level, the obesogenic environment can flourish. Some examples of this may be road infrastructure and whether it supports walking and cycling. Policy and legislation on school meal provision, locations of fast food outlets and access to recreational facilities for families. Some work has been undertaken to understand the obesogenic environment within a UK context. A study conducted in the North East of England found a positive association between the walkability of an area (i.e. the extent to which an area's infrastructure may encourage walking), and food availability with BMI and fruit and vegetable consumption in the local population.

The impact of advertising and exposure to high calorie food has also been incorporated into conceptualisations of the obesogenic environment. Research has suggested that frequent exposure to images or reminders about high calorie food encourages preferential choice for that food in adolescents (Watson et al., 2016). While work is being done to understand how the obesogenic environment may increase levels of obesity, the complexity and variability is such that definitive conclusions cannot be drawn (Lake & Townshend, 2006). This has the potential to undermine the concept and its validity as there appears to be no one definition of what it means.

1.6.3 Psychological understandings of obesity

Within psychology there have been attempts to understand obesity from different theoretical models. From a psychodynamic approach Susie Orbach conceptualises the way in which women's relationship to eating and their bodies has been damaged by an abusive patriarchal society which objectifies women and holds very specific ideas of beauty which center on thinness. Orbach's hypothesis positions overeating and obesity as expressions of

painful inner conflicts and expressions of the unconscious (Orbach, 1989). In a society that views larger women as anti-men, Orbach states that women's over-eating can be understood through the lens of gender inequality. Instead of the dominant idea that excess weight is owing to a lack of willpower and discipline, Orbach states that for women, fat acts of protection; an expression of boundaries, nurturance, strength, and rage (Orbach, 1989).

Cooper (1997) draws on the social model of disability to conceptualise the way in which larger people are disabled through a lack of access to the social world, for example; the size and layout of social spaces, clothing sizes and frequent exposure to discrimination. Medicalisation of obesity says people must be fixed or cured from their excess weight, and that larger bodies are unable to function normally, thus they become marginalised.

Guidance from the BPS outlines how psychology can contribute to obesity policy and practice (BPS, 2019). In taking a biopsychosocial approach, a de-medicalised and interactional approach is promoted. The impact of stress is emphasised; as is the impact of poverty and discrimination on people's lives. and how this contributes to understanding the social gradient of obesity (BPS, 2019). The document presents evidence regarding the impact of food restraint, its association with weight gain over time and psychological distress. This provides an alternative to the dominant dieting narrative which exists in both popular media and within the medical profession. The impact of weight stigma is also highlighted, with evidence demonstrating the negative health impacts of weight stigma highlighted. The report suggests the development of an integrated approach to obesity prevention and management which takes into consideration the multi-faceted and complex nature of the phenomenon. Psychologists are positioned as being able to make a meaningful contribution through providing a psychological and systems perspective to research, policy, and clinical contexts.

1.7 Medicalising obesity

Medicalisation refers to "defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it" (Conrad, 2005). The process of

medicalisation is often assumed to come from within the medical profession itself, however there are several drivers, such as the media, pharmaceutical industry, government, consumers (van Dijk et al., 2016). Medicalisation and the use of medical diagnosis holds a particular social power. Not only does it legitimise medical systems, it also provides a mode of communication; defining meaning of experience and reality, which it then reinforces. Diagnosis also maintains particular social structures, for example, bureaucratic systems (Rosenberg, 2002).

There are significant financial implications for medicalisation which are important to consider in thinking about push factors. In the UK there is an upward trend in healthcare costs (Office for National Statistics, 2020). While a public health model exists in the UK, the existence of private healthcare brings about a profitable market for health. A developing market offering options such as diagnostics and nutrition allows for marketisation of an increasing number of medical and healthcare products and services. Increasing use of technology, often by private corporations may increase costs of healthcare excluding proportions of the population from healthcare interventions. (Contino, 2016).

Within a framework of medicalisation there is a risk that problems are considered without due attention to the contributing social conditions, risks, and inequalities. This is particularly pertinent to the issue of obesity where social deprivation is a predictor of obesity (El-Sayed et al., 2012; Keaver et al., 2019). Where the social context is missed, responsibility for addressing health is health left with the individual (van Dijk et al., 2016). This may exacerbate health problems and social inequalities.

Some work has focused on how dominant conceptualisations of obesity can influence social realities and opportunities. Jutel, (2006) argues that medicalisation locates obesity as inherently unhealthy. However, this is not always reflected in research. While overweight is associated with increased mortality, so too is underweight (Aune et al., 2016). Thus, raising the question; why is the focus on obesity? Jutel (2006) argues that increased medicalisation results in increasing commercial opportunities, for example through weight loss products and technologies. Social pressure to lose weight then creates and sustains this market.

The concept of the 'sick role' dates to the mid twentieth century (Parsons, 1964). Parsons views illness as deviance which disrupt normative expectations for a person to fulfill within a capitalist society, such as work and family obligations. Illness is seen as one of the most significant withdrawals from society, potentially resulting in a loss of esteem and consequences for the allocation of resources and social standing. The sick person has two rights and two duties to fulfill. The first duty is to recognise that sickness creates dysfunction. The person occupying the sick role is then tasked with seeking assistance to cope with their sickness, whereby advice should be followed. The fulfillment of these two obligations enables the sick person the rights of being exempt expected societal obligations and from blame (Parsons, 1964). Increasing prevalence of chronic illness means that expectations of social functioning have changed in recent times (Crossley, 1998). Under British social policy in the past decade, more people with long term illness are expected to participate in employment and are thus denied benefit payments for disability (Disability Rights UK, 2018). People with obesity may be deemed not to be following sick role expectations to engage with weight loss attempts until they reach a lower body weight. A perception that they are not doing this, by remaining at a higher weight, may result in them being viewed as deviant.

In 2013 the AMA officially classified obesity as a disease (Pollack, 2013). This followed several decades of movement towards medicalisation (Kyle et al., 2016). Proponents of disease classification point out that more funding for obesity treatment and research will be made available, resulting in improved healthcare outcomes on an individual and population level (Kyle et al., 2016). Medics have argued that the health-related risks associated with obesity, its chronic nature and similarities observed between obesity and communicable diseases further the arguments for disease designation (Bray et al., 2017). In arguing for disease designation, the world obesity federation state that other diseases have effectively been controlled by environmental changes, for example, improved sanitation. Thus, similar environmental changes could be made following the designation of obesity as a disease (Wilding et al., 2019). This argument raises some challenges in that it acknowledges the role of wider societal factors in the increase in obesity. Communicable diseases are often controlled through environmental factors such as sanitation (Wilding et al., 2019). However, this statement confuses the discussion as it both likens obesity to a communicable disease,

while acknowledging the need for social and political change in the prevention of obesity. Proponents of disease designation have also highlighted that it may influence politicians and policy makers to move from the prevailing view of obesity as a lifestyle choice and towards an understanding that encompasses genetic, biological, and environmental factors. It is hoped this in turn will support policy that can positively impact environmental factors associated with obesity (The Lancet Diabetes & Endocrinology, 2017). Research has indicated that disease designation influences how overweight people respond in relation to medicalised language. Findings suggest that people exhibit decreases in healthy self-regulatory behaviors, and concern for being overweight (Hoyt et al., 2014).

Following the AMA statement some research has begun to emerge regarding public perception on the classification of obesity as a disease. However, UK data is limited. Survey data from a United States study highlighted that most people were in favor of the move (Puhl & Liu, 2015). The study found that those expressing higher levels of weight stigma were less likely to support the decision (Puhl & Liu, 2015). Interestingly, political leanings have been identified as a predictor for how people view the types of policy approaches that should be employed in relation to obesity. Those with a left-leaning political orientation are more likely to support interventions that protect individuals and diffuse responsibility for obesity into the wider factors. Those with right-leaning political ideologies were more likely to support punitive approaches to weight management (Puhl & Liu, 2015).

A separate debate in the UK as to whether obesity should be designated as a disease is currently underway. There are vastly differing opinions and it is likely that the consequences of this move would be significantly different to the United States. In the UK some argue that recognition of obesity as a disease would encourage people to seek help, while others feel it would reduce personal responsibility and be disempowering for patients (Wilding et al., 2019). In 2018 the Royal College of Physicians formally and publicly stated their support for disease designation (Royal College of Physicians, 2018). The aim of this move as stated is to reduce stigma and ensure that obesity is prioritised in a whole systems approach which focuses on prevention as well as access to treatment for those who need it.

It is hoped that disease designation will bring about reduced stigma towards those living with obesity and more resources will be made available for support and research. (Rosen,

2014; Wilding et al., 2019). Hoyt., et al. (2017) highlight that the conceptualisation of obesity as a relatively fixed, genetic, or hormonal condition can reduce blame and modify beliefs that obesity is subject to controllability. This in turn results in a reduction in stigma and anti-fat prejudice However, another study found that the framing of obesity as a disease did not influence attitudes (Ata et al., 2017). The argument regarding disease designation's capacity to reduce stigma is problematic. Other examples show that stigma exists towards a host of medical problems. Despite medicalisation, both HIV and mental illness remain highly stigmatised, whereas conditions such as cancer tend not to be. This suggests that medicalisation is not sufficient to reduce stigma (Thibodeau et al., 2015). It also points to the importance of the social context and meanings that are applied to issues in determining public attitudes to health problems.

Some within the medical profession who oppose disease classification argue that it would be disempowering for patients and risk reducing motivation and autonomy. That the real benefit will be for industry rather than patients (Wilding et al., 2019). It is interesting to note the language being used to oppose the move which tends to be centered on a narrative of personal responsibility and choice, rather than a wider acknowledgement of systemic factors. Other research has highlighted that the much-quoted mantra "eat less, move more" which often involves strict and rigid dieting and restriction results in increases in obesity and eating disorders (da Luz et al., 2017). Thus, promoting dieting as way to improve health is likely to have significant iatrogenic effects.

The BPS have taken a position of opposing disease classification of obesity (BPS, 2019). They argue that this would be likely draw attention away from the social (Pickett et al., 2005) and psychological aspects of obesity and may reduce the likelihood that interventions would include psychological or behavioral support. Psychologists are well placed to support more nuanced understandings about why some people are more likely to have difficulties with their weight. Despite the BPS incorporating social and systems-based issues into their understanding of obesity, and resisting the move towards disease classification, the overall approach at times remains individualistic in its approach, for example, though use of behavioural modification interventions.

Obesity is politically contentious. In January 2019, the Conservative Secretary for health, Matt Hancock made a statement to the All Parliamentary Group on Obesity. This statement expressed opposition to disease designation as it is a “condition borne of human behavior”. Mr. Hancock stated an aim toward prevention of obesity, and “empowering” families to make healthy decisions. While acknowledging that there are environmental contributing factors, the health secretary focused on behaviour change and personal responsibility in reducing obesity (All Parliamentary Group on Obesity, 2019). It is interesting to note the language used, which is individualised in focus and privileges behavior change over addressing inequality. This reflects wider views and attitudes towards obesity, which reinforce weight as an issue that is personal, behavioural, and is associated with failure; personal, moral, or a failure of motivation.

2.9 The current study

The above literature review highlights that people of a higher weight interact with systems that are medicalised and where ideas about individual responsibility for body weight and health dominate. Furthermore, their body size is often viewed through a moral lens where associations with laziness and lack of intelligence are attributed to them. People with obesity must negotiate these interweaving attributions, which arise across a range of contexts and interactions.

This study seeks to examine the lived experience of obesity in the context of these factors. In taking a phenomenological approach, this study will explore how these messages are internalised and embodied by people who have accessed NHS weight loss services. Interviewing people who have accessed NHS weight loss services will mean that participants will have encountered medicalised explanations of their weight. This will allow for an exploration of how this is navigated by participants, as well as how it informs lived experience.

This study aims to address the following questions:

1. How do people who have accessed NHS weight loss services make sense of obesity?

2. Secondly, how does the lived experience of being obese influence how people living with obesity engage with the debate concerning disease designation of obesity

Chapter 2: METHODOLOGY

This chapter provides an overview of the methodological approach taken in this study. It begins outlining epistemological considerations, discusses a rationale for the adopted analytic method, and explores related ethical issues and consent. Finally, an overview of the data collection process and analysis will be provided.

2.1 Epistemology

As this study seeks to understand lived experience, a phenomenological epistemological approach has been adopted. This approach allows for an exploration of meaning and experience. Phenomenology is a practice which seeks to understand phenomena as they are experienced through consciousness. This approach is a distinct epistemological position which focuses on the experience of thinking and knowing (Moran, 1999). Phenomenology conceptualises experience as being rooted in culture and values, where experience cannot be de-coupled from the societal ideas, norms, and expectations (Carel, 2011).

The work of Merleau-Ponty focuses on human experience arising through perception. Thus, experience is always embodied as it is received through the senses (Merleau-Ponty, 1962). In his approach, Merleau-Ponty states that embodiment, perception, action, and subjectivity are interwoven, and thus the body and the self cannot be separated. The body and mind are one. The body is objective-subjective, in that it can be subject to objective measurement. However, it is also the container of subjective experience and perception. Thus, the body can be experienced from both a first-person point of view, and a third person point of view (Merleau-Ponty, 1962).

A phenomenological approach to health can help to examine the experiences of those experiencing ill health. The objective-subjective nature of the body makes phenomenology an appropriate practice for understanding the experience of health and illness (Carel, 2011). Usually, the body is taken for granted until something goes wrong. Thus, ill health is not just physical, but laden with meaning and psychological and social experience (Carel, 2011).

Weight based difficulties are particularly interesting to look at through this lens as they are an example of the objective-subjective experience, where the subjective experience holds social meanings regarding morality and stigma. The phenomenological issue of embodiment is pertinent to difficulties with weight, as well as how ideas about weight may influence a person's view of their body, their relationships, or identity. It is likely that these issued will in interviews. Therefore, a phenomenological approach is appropriate to address this.

There are several other approaches that exist within phenomenology. For Husserl, the focus of understanding experience is through consciousness. Husserl refuted the notion of a mind-body dualism, positing that minds and objects occur within experience (Moran, 1999). Heidegger, who challenged Husserlian phenomenological ideas, stated that the experience of being could be understood in the account that one gives for their existence and the meaning it brings to daily life. Heidegger rejected the notion that humans were simply observers of objects in the world, espousing that both subject and object are inseparable (Horrigan-Kelly et al., 2016).

2.2 Choosing IPA as an analytic method

IPA is the chosen method of analysis for this study. This study sought to draw from the works of Merleau-Ponty who was concerned with the way in which perception informs experience. IPA is an approach that focuses on the lived experience of participants and seeks to look in detail at how people make meaning. IPA is particularly appropriate for complex and emotionally laden topics (Smith & Osborn, 2015). It also allows for the expression of experience on people's own terms, rather than through a pre-existing lens or framework (Smith & Osborne, 2015). This is particularly relevant to this study which is

interested in sense making and how people draw on their experiences and dominant ideas about obesity to develop their conceptualizations of obesity.

IPA is an approach that seeks to understand the experience of participants through their perception of the world. It recognises that research is always an interpretation of the participant's experience which is influenced by emotions, motivations, and desires (Smith & Shinebourne, 2012). IPA takes an inductive approach. This means that interpretations are grounded within what has been said by the participants, rather than trying to test out a specific theory or hypothesis (Smith & Osborn, 2015).

IPA has origins in hermeneutics. Hermeneutics is concerned with interpretation and meaning. For Heidegger, interpretations are grounded in prior experience, assumptions, and pre-conceptions. Therefore, new experiences are always seen through the lens of these (Smith, et al. 2009). In this approach the researcher takes a dynamic and active role in their interpretation of the material (Smith & Eatough, 2007). IPA follows a double hermeneutic process, in that the researcher is trying to make sense of the participant trying to make sense of their experience. Therefore, interpretation is complicated by the researcher's preconceptions, biases and assumptions about the topic or participant (Smith & Eatough, 2007). Hermeneutics reaches beyond a simplistic idea of interpretation. It requires an appreciation that interpretation cannot be de-coupled from its cultural and historical context. The researcher already holds preconceptions and assumptions about the topic in question (McLeod, 2020). This suggests that adopting a reflexive approach is important to ensure integrity of the research. Researcher reflexivity will be discussed in more detail in chapter 4.

In taking an idiographic approach, the researcher seeks to create an in-depth focus, with a detailed and fine-tuned analysis (Smith, 2004). As IPA commits to a detailed analysis of examination of one case or a small number of cases. Beginning with a detailed analysis of each case, an IPA analytic approach then moves to looking towards similarities and differences between cases. This process allows the researcher to produce meaningful patterns and reflection on shared experiences (Shinebourne, 2011).

As discussed, this study draws on the work of Merleau-Ponty, whose take on phenomenology was rooted in concepts of embodiment. Merleau-Ponty's (1962)

description of perception as being rooted in experience through the senses breaks down the separation of mind and body. As this study is interested in the lived experience of weight difficulties, the ideas of Merleau-Ponty, particularly those concerned with embodiment, allow for an examination of how people of a higher weight engage with social concepts of weight, including stigma and how these are then incorporated into the experience of being of a higher weight.

A qualitative approach was adopted, which was made necessary by the complexity of the issues addressed in this research and. This approach is necessary for undertaking a study that is rooted in phenomenological epistemology, while also allowing the researcher to engage with experience and meaning, or the "quality and texture of experience" (Willig, 2001, p.8). Qualitative research allows for the exploration of how people experience their social world and how they make meaning (Willig, 2001). Taking a qualitative approach allowed the researcher to demonstrate flexibility and responsiveness to the issues that were raised. It allowed participants to express their experiences, and crucially, the meanings attached to their experiences. This approach also helped to minimize researcher bias because of the flexibility that was incorporated, this meant that participants were free to discuss issues that were not directly asked by the researcher.

2.3 Recruitment

The Obesity Empowerment Network (OEN) supported the recruitment for this study. The OEN is a user led advocacy group which dedicates itself to empowering people with obesity and amplifying their public voice. The mission of the organisation is to improve access to healthcare for persons living with weight difficulties, advocate for nationwide prevention strategies and reduce weight-based discrimination and stigma.

The OEN was identified as an appropriate group to advertise the study through as it was thought to be likely that some members would meet the inclusion criteria and may be interested in participating. The study is also in fitting with the mission of the OEN, which is to amplify the voices of those living with obesity and obesity stigma, as well as adding to public and policy discussions regarding obesity.

The organisation was founded by individuals living with weight difficulties, in addition to professionals working in obesity and bariatric surgery. As one of the supervisors of this project is a member of the OEN, it was agreed that the organisation could be approached to advertise the study. The steering group of the OEN were approached and the study aims discussed with them. Permission was granted for recruitment to proceed (Appendix B). It was agreed that an advertisement seeking participants would be sent to those on the OEN mailing list. Advice regarding GDPR regulations was sought and followed.

2.3.1 Criteria for participation

Participation criteria for the study were decided based on the research questions and in consultation with the project supervisors. The criteria for participation were: Adults who accessed NHS weight loss services, such as GP support and advice, multi-disciplinary community-based interventions, or surgical and medical services, including bariatric surgery. This relatively wide criterion was chosen for several reasons. Firstly, a significant proportion of individuals who are referred for bariatric surgery may not proceed to surgery for several reasons, for example, surgical risk being assessed as too high. It was important not to exclude such people from the study as their experiences and ideas are relevant to the obesity as a disease debate. They are also likely to have had significant contact with NHS services. The literature review highlighted that in the British context, the service-user view was largely absent from the "obesity as a disease" debate, and this study aims to address that gap, thus it was decided that contact with some form of NHS weight loss service was a necessary criterion for participation.

2.4 Process

2.4.1 Semi-structed interviews

Support from the supervisors, both of whom have experience in the field of clinical health psychology was sought in developing the interview schedule (Appendix C). Initial questions focused on getting an understanding of each participant's contact with NHS weight management services. Questions about the experience of living with weight difficulties were incorporated into the interview questions to understand how messages about weight are taken on and embodied by people. The final questions focused on participants' interaction with the "obesity as a disease" debate and how this might link to their experiences of living with weight difficulties. Each participant was informed that they were welcome to bring ideas and experiences that may not have been covered in the interview schedules, and each participant was given the opportunity to add content during the interview. Following the earlier interviews, a review was conducted with the supervisors to examine the appropriateness of the interview schedule. During this discussion, some minor changes were made to the sequencing of questions and more flexibility was introduced, by less stringently asking questions in order. The result of this was that interviews flowed more and felt more conversational.

2.4.2 Recruitment and Interviews

The OEN arranged for an administrator to circulate the recruitment poster (Appendix D). Interested individuals then began to contact the researcher on the email address that had been provided. All emails were acknowledged. For those who met inclusion criteria, the information sheet (Appendix E) was sent by email. The researcher also offered to discuss the project with potential participants over the phone, and in one case did so.

Each participant was offered the chance to attend the interview at the University of East London (UEL) or to conduct it over the telephone or skype. All participants stated a preference for conducting the interview over the telephone and via skype. Interviews took place during working hours and were conducted from UEL so that support could be easily accessed if any risk issues arose.

Information forms were reviewed verbally prior to starting the interviews to ensure each participant fully understood what participation entailed. Time was allowed for questions

before and after the interviews. Participants were required to sign and return the consent form (Appendix F) via email before beginning the interviews. Interviews lasted between 49 and 88 minutes. UEL provided a dicta-phone for recording the interviews.

Following the interviews, participants were offered the opportunity to ask further questions. Some asked about the study and plans for publication and these were discussed. Participants were provided with a de-brief form (Appendix G) and advised they could get in contact via email if any concerns arose.

2.5 Ethical issues

Ethical approval from the University of East London was obtained on April 8th, 2019 (Appendix H).

2.5.1. Informed Consent

Information forms were re-visited verbally prior to the commencement of the interviews, and information regarding rights to withdraw data was provided verbally and in writing (Appendix E), as were time limits to withdrawal. At the end of each interview participants were reminded they could contact the researcher should any concerns arise. The de-brief form provided information on sources of support that could be accessed if required. Participants were informed that they could withdraw their data at any time until 1st of February 2020. This date was chosen as it would give participants up to four months to change their mind and because data analysis and write up was anticipated to begin at this time. No requests to withdraw participation were made.

2.5.2 Potential Distress

Whilst it was not expected that the interview would be distressing for participants, it was considered possible that distressing or difficult personal material might arise. Prior to commencing interviews, it was explained that if concerns about risk to the participant or

another person were identified, it may be necessary to break confidentiality. If this were to occur it would be discussed with the participant where possible and support from the project supervisor would be sought. This was also highlighted in the information sheet. After completion of the interview, participants were provided with the de-brief form and advised to contact the researcher if needed. While it was made clear that the researcher could not offer emotional support, participants were made aware that the researcher could suggest services that could be of help. No risk concerns were identified throughout the interviews and no participants made contact following the interviews to seek support.

2.5.3 Data protection

Steps were taken to ensure confidentiality, anonymity, and the protection of research data. Multiple methods of data storage were used to protect information, for example, UEL one drive, and UEL B: drive. Consent forms were stored separately to all other data collected.

The researcher transcribed all interviews, removing all identifying information including names and locations.

A research data management plan was developed by the researcher and approved by the University of East London (Appendix H).

2.6 Data Analysis

2.6.1 Familiarisation with the data

The principles set out by Smith, et al. (2009) were consulted before commencing analysis. Following transcription, which was completed by the researcher, the interviews were read several times. Revisiting transcripts is important as new insights can be gained upon each reading (Smith & Osborne,2003). This was done to develop familiarity with the data and to begin making initial observations. Initially, the transcripts were read while listening to the recordings to ensure accuracy as well as listening to tone and emphasis. Following the initial

readings, transcripts were re-visited one-by-one, and handwritten notes were made in the left-hand column of the transcript (Appendix I). Reasons why they were chosen were noted. Notations focused on the content of the words, use of language that emphasised an experience (for example, a distressing memory) or emotion, and comments that were concerned with making sense of difficulties with weight (for example, self-blaming language). The process was repeated for each of the eight transcripts.

2.6.2 Coding and developing themes

As patterns within the data became apparent, possible themes were identified and recorded (Appendix J). Words and phrases that appropriately captured what had been said were used to begin bringing together salient issues that were present in the data. The developing themes at this stage were recorded using NVivo software. It was deemed likely that these would change over time and thus were seen to be initial, flexible themes.

Themes were coded and organised according to the theme group they were deemed to represent in this early stage and given tentative a 'superordinate' theme. Themes were linked to text in the data that they represented (Appendix K). Themes were re-visited and considered alongside the interview text before being finalised. Themes were not chosen to simply represent prevalence in the data (Smith and Osborne, 2003), but factors such as their salience to a person's experience were also considered. Examples included experiences that were very distressing or that seemed to hold significance for them that they may have not spent a long time in the interview discussing, but were pivotal, nonetheless.

CHAPTER 3: ANALYSIS

The following chapter discusses the findings of this study and is organised by the themes that were developed through the analytical process. The themes are represented visually below.

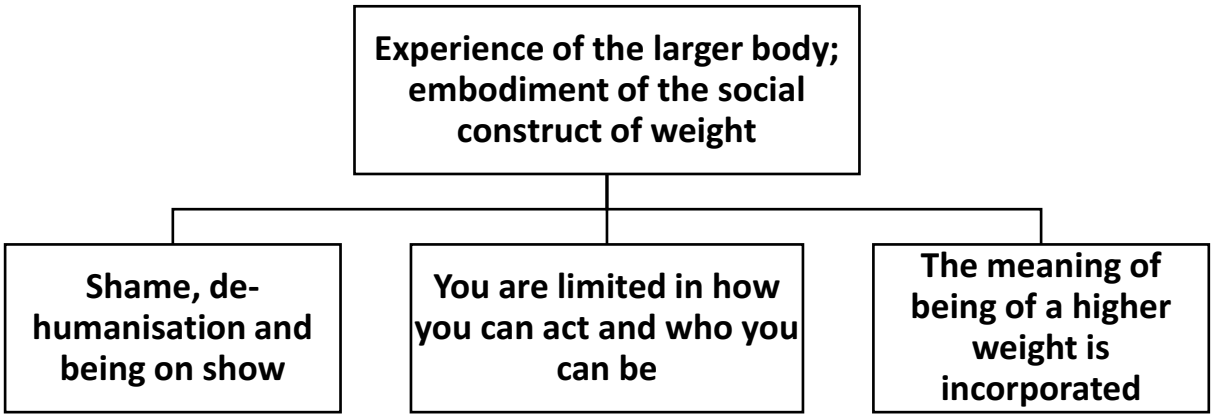
3.1 Participant demographics

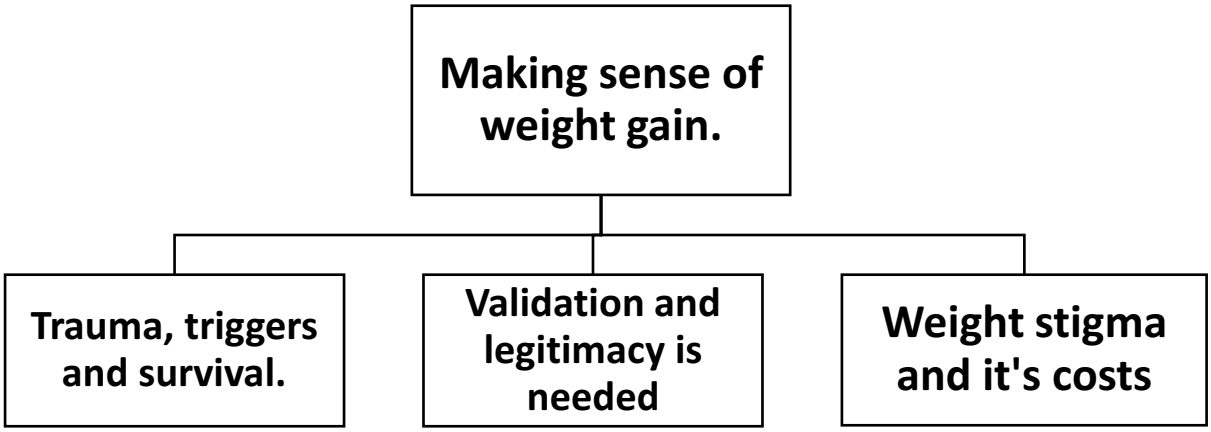
Table 1 (see below) provides an overview of participant demographic information and information relating to their contact with NHS weight loss services. All names used are pseudonyms which have been used to protect participant confidentiality.

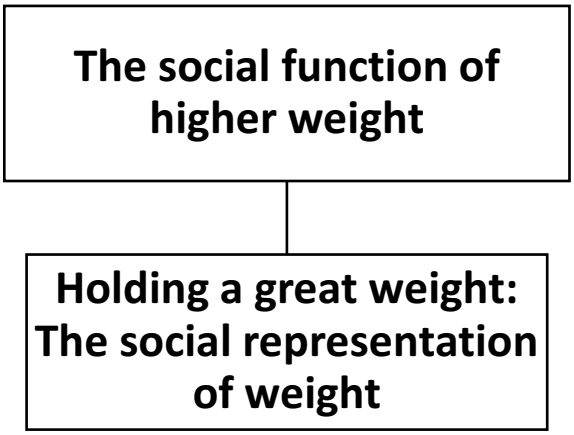
Name	Age	Ethnicity	Gender	NHS services accessed	Interview duration
Catherine	50	White British	Woman	Primary care via GP. Local weight loss programe. Various referrals to NHS dieticians. Weight loss dietician in childhood.	64 minutes
Shannon	38	White- other	Woman	Bariatric surgery referral.	54 minutes
Lisa	60	White British	Woman	Bariatric surgery.	67 minutes
Jenny	67	White British	Woman	Primary care. Bariatric surgery referral.	80 minutes
Emma	54	White British	Woman	Primary care- GP. Bariatric surgery.	62 minutes
Liz	71	White British	Woman	Primary care- GP and nurse. Referral to bariatric surgery.	88 minutes
Rachel	39	White British	Woman	Primary care- GP, dietician. Bariatric surgery.	81 minutes
Tina	43	White British	Woman	Primary care- GP. Dietician. Bariatric surgery.	49 minutes

3.2 Map of the themes

Figure 2 provides a visual represntation of the themes developed through the analysis of the data.




Making sense of weight gain.
Trauma, triggers and survival.
Validation and legitimacy is needed
Weight stigma and it's costs


The social function of higher weight
Holding a great weight: The social representation of weight

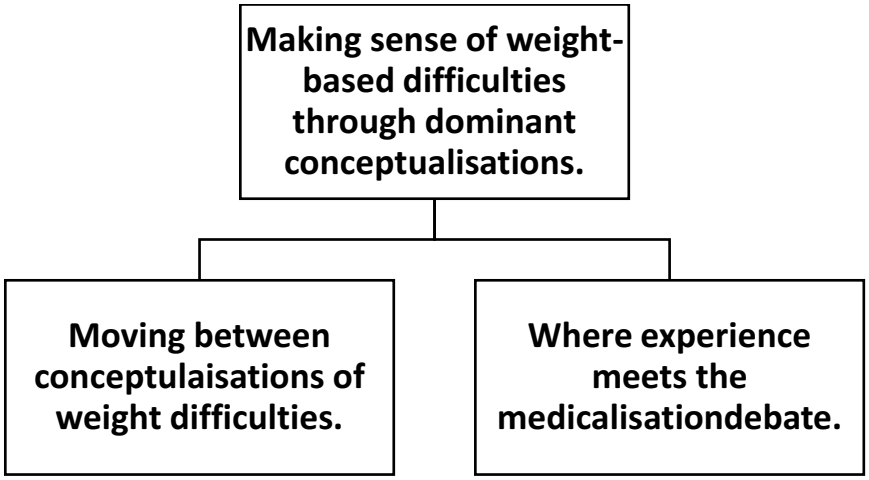


Figure 1: Map of IPA Themes

3.3 Theme 1: Experience of the large body; embodiment of the social construct of weight

Theme one describes participants' experiences of being large. This experience is often informed by feedback from others and considers how the social construct of higher weight as wrong or immoral is experienced and internalised by participants.

3.3.1 Sub-Theme 1: Shame, de-humanisation, and feeling exposed.

For all participants, the theme of shame and de-humanisation was a discussed as a common experience. Exceptions to this experience were rare and experienced as surprising and unusual. Shame and de-humanisation are experienced in multiple forms; subtle and explicit. So frequent is this, that it informs how participants relate to others, self-expression, and movement. The experience of feeling exposed or on show because of one's size was expressed numerous times. The feeling of being exposed was amplified by the way in which others made comments about their body or undermined their choices. Attempts to counter these experiences by hiding or through a desire to become invisible were discussed.

For Catherine, the experience of de-humanisation was extremely stark. Relationships and basic humanity are undermined by one's physical appearance as a person of a higher weight.

> *Catherine: It was, I mean at 24 stone nobody really talks to you as a person.*

When she lost weight; Catherine noticed a clear difference in how she was treated by others. To be slim meant that she was treated as a person, she became visible in a way that she had not been when her body was larger.

> *Interviewer: And so, what was it like when you started going back out, when you started to socialise again? You mentioned noticing people reacting to you quite differently, but-*
>
> *Catherine: Yeah, I mean it was a huge boost in my confidence, it's like the small things; people will hold a door open for you. People will smile at you as opposed to just walking past and ignoring you.*

Experiences of de-humanisation were experienced in all spheres of life. The normality and acceptability of this abuse and de-humanisation was marked. Liz recalled the experience of a friend living with weight difficulties:

> *Liz: And poor [friend's name], she said to me, she studied German with me; and she said, the fact is I'm an "untermenschlich" and so are you. "Untermenschlich" means "sub-human" in German. That is how she has been treated. She was working with kids, and they used to run after her saying: "Hey big tits". Nobody intervened.*

So common the experience of being dehumanised, it felt surprising for Liz to be treated kindly and with respect in the context of healthcare. For being treated "like a person" was a rare exception.

> *Liz: -and my doctor then referred me to [hospital name] where I was treated like a person for the first time about my weight. Like a person!*

Alongside the experience of being continually dehumanised was the experience of shame. Living with shame was expressed as part of life when living in a larger body. This was stated very clearly by Shannon.

> *Shannon: For me, my weight is a huge sense- and it has been my entire life- a huge sense of guilt and shame.*

This continual experience of shame not only led to difficult emotions and significant distress but appeared to be incorporated into how participants live and relate to others. For Emma this did not subside after her surgery and after having lost a substantial amount of weight. The shame and fear of being shamed continued, and she experienced considerable anxiety about being exposed in new relationships. Emma also found ways to protect herself from experiencing shame by concealing how much she could eat, so as not to disclose she had undergone bariatric surgery.

> *Emma: I -um- was dating over the last year. I know if someone took me for a meal, I would feel anxious because I didn't want to tell the person all of my medical—it was too much! To tell someone your whole medical history on a first date. So, I would try and avoid dinner and even after two or three dates I would feel traumatised if they said: "Do you want to go for a meal?" Because I'd think: "Oh, Jesus, what am I going to do?" But I became very adept at disguising that I couldn't eat very much.*
>
> *Interviewer: Mm- were you worried about how they would react?*
>
> *Emma: Yeah, I was -um- worried that they would judge me as, I don't know what, judge me badly. I don't know what I thought they would judge me as. But I didn't feel confident enough to say: "Ah, I had weight loss surgery last year. Yeah, I was twenty stone and now I'm only ten." I just didn't feel confident and I felt it was -um- I think I felt they would think the person in front of them was a lie and really I was a fat person disguised as a thin person for tonight [laughs].*

Emma's sense that she is really a "fat person disguised as a thin person" speaks to the way in which the messages surrounding difficulties with weight are incorporated into one's sense of self. The meaning of being a higher weight is embodied to such an extent that the moral implications of "wrongness" are taken into one's identity.

The continual experience of shame and de-humanisation links to many of the participants feeling as though they are exposed. For larger people, their struggles are represented in their size. Here, the embodiment of obesity equates to wearing your experiences externally, being unable to hide one's wrongness from the world. Both Liz and Rachel expressed this clearly.

> *Liz: But the other thing that I feel is that my problems are very visible. My internal dilemmas are on my body, visible for all to see.*

For Rachel, the sense of being exposed endures regardless of her size. This suggests that there is something about what it means to be obese, the shame that is associated with it, that is held onto, regardless of her size. Rachel also implies that her difficulties with eating and worries about food do not subside with a reduction in her weight- the experience of constant self-monitoring prevails.

> *Rachel: So, I think we all have a trigger. The difference is you can see mine. And I don't mean that you can see that I'm in a restaurant and I'm trying to debate what to eat and I'm googling the calories, or whatever. It's the fact that whether I'm a size twelve and in my head I'm still a size twenty-eight. Or I'm sitting there, literally a size twenty-eight. You can see my inner shame in a way that someone is a daily alcoholic or a chain smoker or who was a kleptomaniac or a shop lifter, you can't see all of that.*

Throughout the interviews each participant spoke of their experience of their body being subject to scrutiny, objectification and un-invited comments or advice from others. In addition to a sense that their struggles were physically embodied and observable, participants felt intruded upon and exposed by uninvited comments and advice giving from others. The lived experience here is of the body not being one's own, becoming a despised other that is subject to monitoring and scrutiny.

Lisa spoke of her experience of her choices about her body and health being undermined by her boss. Lisa recalled speaking to her boss about planning time off work following her bariatric surgery. The response of her boss was to give her advice, undermine her opinion

and infantilise her, in questioning her decision. This reflects a sense that people of a higher weight are not competent either generally, or in terms of caring for their own health.

> *Lisa: I had to tell my boss at work, because obviously I was going to need time off work when I went in, and the look on her face was: "Ugh Lisa, why are you doing that?" "Because I need to!" "But you are doing so well", she said. "No, I'm not, I need the help and I'm going for the help!" "Alright ok, then", she said. "At the end of the day it's your decision if you think it is right, but I don't think you should". "Well like you said it's my decision", I said, "I will keep you informed as to what I am doing". She said: "Have you told your mum and dad?". I said: "No!" She said: "Oh but they need to know, what if something happens to you on the operating theatre?" I said: "Nothing is going to happen to me in the operating room. My husband and children know and that's all who needs to know". "Well, as long as you are sure", she said. I said: "I am sure, I am not a child, I know what I am doing".*

Shannon highlighted the double standards that exist. If a person is larger, they are automatically subject to public scrutiny and judgement in a way that people who are a smaller size are not. This leads to further exclusion and isolation.

> *Shannon: The one I like to think about is; if I go around the high street and I'm eating a yum-yum from Greggs, everyone is going to be judging me for eating that yum-yum. But a teenager can have a crush-em from the KFC and get on the bus to go one stop, and I'm walking down the high street.*

For most "normal" size people, eating a pastry while shopping or travelling, is unlikely to be seen negatively by others. However, Shannon's experience highlights the level of scrutiny that large people experience in terms of their food choices. Judgement from strangers is extremely intrusive and may begin to influence larger peoples' choices and behaviours.

For Tina, the congratulatory approach from others when she lost weight was difficult to bear. The idea that her body was not her own, or for herself was implicated in how people treat her in relation to her size.

> *Tina: I've never relished when people notice. So, when people say: "Oh, have you been on a diet? You look like you've lost weight". I've never coped with any of that at all*

[laughs]. And -um- I don't know, I think that some of that assumption that when you lose weight it's for other people or to be noticed and that. I've always found that really uncomfortable when people comment on weight.

For Jenny, the normality of strangers feeling able to comment on her body was a part of her experience. Jenny's expression of the idea of there being no such thing as "Fatism" demonstrates the social acceptability of discrimination and abuse of larger people. People of a higher weight are objectified which may contribute to the feeling of being exposed. There is an expectation that they should deny themselves food to be "good".

Jenny: And the way people look with such disgust, even when you are eating normal meal, and a normal amount. It's well: "She shouldn't really be eating, you know, she's too fat to eat".
Interviewer: Is that strangers, family, friends?
Jenny: Well, complete strangers feel they have the right to make comments.
Interviewer: Yeah?
Jenny: It's the last thing that there is no— "Fatism" [laughs] there should be something. They shouldn't be allowed to do that, really, you shouldn't. if you are going to say you shouldn't make comments because someone's a female, or someone's old, or someone's—even old, you are allowed to do that a bit.

3.3.2 Subtheme 2: You are limited in how you can act and who you can be

Self-expression and ways of being in the world are limited for a large person. They are limited to specific roles and personality expressions which are socially acceptable and comfortable for others.

An expectation or need to hide their body when larger may a way to protect themselves from the experience of being exposed. However, the pressure to do so is distressing. While protective, the idea of making oneself invisible minimizes expression and impacts relationships.

Shannon: My mother always told me "we big ladies, we have to wear black and brown clothing, dark clothing so we don't stick out, so that we are not drawing attention to ourselves".

Not only does Shannon's comment indicate that self-expression is deemed unacceptable for larger people, but it highlights an expectation for large people to occupy less space and to be less visible. This links to the previous sub-theme in that it may be an attempt to reduce feelings of being exposed. However, it may also be a way of reducing others' "offence", dressing in colorful or form-fitting clothing may be perceived as representing a refusal to shrink or minimize the body, which carries immoral connotations.

Emma: If I was going somewhere, I would have a great big wardrobe trauma: "Maybe I should wear this, maybe I should wear that". Trying things on, trying to make my body smaller by, you know; "maybe if I wear this black cardigan, maybe it will disguise me".

Lisa: if I did go out, I would hide in the corner and I would have to have quite a few glasses of wine before I would dance.

Interviewer: why was that, why did you stay in the corner?

Lisa: Because I hid myself away, because I was so big, I hid myself away, I didn't want people to see me, but I wanted to be there.

Liz spoke about feeling as though there was only one way, she could express herself, and that was to take on the identity as the "fat funny girl". This was the only way she could find to be accepted and acted as a protection for her.

Interviewer: It's like, you know, any expression at all of what you experience in relation to how others are around you is completely pushed away.

Liz: You can't, you're the funny fat girl. And you make huge efforts with your personality to be funny, entertaining, interesting.

For Tina, having a large body was a reason for self-exclusion from things in life that are enjoyable. Activities that risk showing the body or demonstrating particular movements are an increased source of shame.

Tina: I mean I've always felt incredibly awkward with things like exercise, going to the gym. I mean, I didn't go to gym classes, aerobics classes, swimming anything where you'd be more self-conscious about your appearance either because of what you are wearing and yeah, so I would say that has had an impact. Because I remember being quite young and I used to be very outgoing, I used to do singing and drama and that, but I would never have done it since.

3.3.3 Subtheme 3: The meaning of fat is incorporated

Participants spoke about their life-long difficulties with not just managing their weight but the internalised associations of being a large person. Participants have taken on these meanings and they are present in relationships and in their own self-concept.

Liz spoke about the idea of stability and reliability. Her larger body indicated to the world that she was neither of these things, making her an undesirable partner for a man. Her fluctuating weight is incorporated to her sense of self, and through this, she feels she is an unreliable person, a problematic person. The responsibility for this is held by Liz, her weight speaks to her ability to be trusting and reliable partner in a relational sense. These issues are not just termed with respect to her appearance or health, but as a reflection of her ability to relate, to care and to maintain a relationship.

Liz: And a friend would say to me: "You know you are gorgeous! You are absolutely gorgeous; they must have been falling over themselves!" "Well no! My weight is fluctuating by four, five stone. How could a man rely on that? I can understand that, it's not that I think they are wrong, they are biologically programmed to like a good-looking woman -um- and a woman who is not going to be a problem. So, you know; I was a problem. And it was apparent I was a problem.

The morality and judgement associated with being of a higher weight is taken on by people in how they view their core personhood. The belief that one is inherently bad was discussed

by Jenny. She internalised messages about her worth being tied to her weight from very early on in life and carried this with her.

> *Jenny: I was convinced I was a- underneath that I was a really bad person. I didn't know why or what. And I didn't want to find out either, but I was very scared that if anyone got to know me, they would find out what an awful person I was. What a horrible, selfish, and lazy person I was. Those were adjectives my parents had used.*

All participants spoke of how they had spent most of their lives trying to lose weight. However, at a smaller size the consequences of having internalised the meaning and attributions of fat did not change. This was much more difficult to shift and stayed a part of people's identity, relationships, and daily living.

> *Catherine: I mean there is not a single job interview I haven't been to where I haven't sat there and thought- I mean everyone thinks about the way they look at a job interview. But, for me it's like, it's like having an imaginary friend, it's always bloody there. It's the seat you choose on the bus. And I say this having been a size twenty-eight and having been a size twelve. And sort of feel the same through all of it. What seat you take on the bus, who sits down next to you. When you're on a plane, is the person next to me going to think I'm taking up too much space? The only way I can describe the presence of fat is this imaginary friend that is with you everywhere. You go to a job interview and you think: "Do I cross my* legs*? Do I not cross my legs?". When you go to a clothes shop and try something on and think: "What does it look like when I sit down, and from behind?" When you go on date, it's not just: "Am I going to like this person?" Its: "do I look bigger than my photos?"*

3.4. Theme 2: Making sense of weight gain

Stories of difficulties with weight gain and their origins were spoken of in the interviews. Implicit throughout the interviews were narratives centred on trauma, life changes and triggers that were clearly linked to a change in eating habits and weight. For some food

became a method of survival. While these themes were woven though peoples' stories, they were often overshadowed by individualised and blaming narratives about weight. Self-blame has been incorporated from wider societal discussions about weight to such an extent that it is difficult to honor relational, systemic, and psychological factors regarding how one's weight difficulties began to emerge. This then linked to how participants engaged with the debate concerning "disease designation of obesity". The on-going health costs of weight stigma were also present in people's narratives, leading to further distress and disengagement from healthcare services.

3.4.1 Subtheme 1: Trauma, Triggers and Survival

Present in the interviews was the significant level of thought, reflection and consideration that had gone into how participants have made sense of their weight and why they may have become obese. Much time has been invested in making sense of weight, this is represented in easily and clearly participants recalled and expressed significant experiences that they linked to weight gain.

Jenny recalled sudden changes to health status in childhood as a time when she began to gain weight.

> *Jenny: When I was six; I had my tonsils removed. Up to that point I'd been a lively kid that couldn't stop, was always running around. Had my tonsils out and I presume it's the anti-biotics, for years I assumed it was the surgery that flipped a switch.*

Jenny's description suggests a "before and after". Once the switch had been flipped, it was difficult to come back to her previous way of being. The suggests a sense of duality, not simply in terms of her weight, but in her experience of her-self and identity.
Jenny also spoke about the way in which food and eating became a way for her to look after herself in what she experienced as a harsh and uncaring environment at boarding school. The reaction of those around her demonstrates why she needed to care for herself.

Jenny: So, I was a very lonely kid. So, yes, eating became my comfort, my way of me looking after myself. I might be sitting next to the teacher at the end of the table and go for seconds, thirds, fourths. And blocking out everyone else, and that they were all looking at me in absolute horror and disgust. But I was just shovelling food down me, I didn't have to talk to anyone, I was busy eating.

Tina recalled the way in which food became a comfort and way of managing difficult times at an early age when her parents were separating.

Tina: *I mean just ironically when my parents were in the process- when the marriage was breaking down. I remember really vividly one evening when they'd had a very verbal argument and things were very heated. So, my dad had rung his parents; my grandparents to come over because things were really stressful. So, the first thing my granddad says is: "Should we go out to KFC?". It's very much that from that age; food is the solution, isn't it? And we'll distract you with a bucket of fried chicken.*

Lisa clearly remembers her life changing significantly after the birth of her children, and the loneliness and isolation of caring for them while her partner worked away from home. For Lisa food became a way of managing the isolation she was experiencing.

Lisa: My husband was away a lot and before the children came along, I was social, I would go out a lot of friends and we would meet up and have coffee and lunch and we would go around to each other's houses in the evening. After the kids came, I couldn't do that anymore, I was restricted because I had these babies and I couldn't just go out, I couldn't just put my coat on and go around to someone's house and say: "Fancy a coffee?" So, I started eating, and that's where it stems from, because, my husband was away, no fault of his, he had a job to do- it stems from there really.

3.4.2 Subtheme 2: Weight Stigma and its cost

The need for legitimacy and support was further underlined by participants' experiences of weight stigma and the detrimental impact this has on physical and mental health.

While Catherine has lost a considerable amount of weight, the pain of seeing her personal training clients being subject to abuse re-ignites painful emotions.

> *Catherine: So, I mean, I have clients who I am working with now who are yeah, where I used to be at 24 stone and some. And even just walking down the road, cars that go past us shout out comments, and, yeah it is epidemic.*
>
> *Interviewer: Wow.*
>
> *Catherine: Everybody feels like they have a right to be able to tell you that you are fat you're lazy, you are a waste of space.*
>
> *Interviewer: How is that you responded, or how you have seen others respond to that kind of judgement, that really really obvious and uninhibited, people saying what they want. What does that do? How do people respond to that?*
>
> *Catherine: I mean, I cry, when it happens when I am out with a client They usually cry as well because it just brings back all the hurt. I mean, even now I can feel that pain and tears in my eyes now.*

The experience of weight stigma from healthcare professionals, for some poses a direct risk to health. Shannon expressed the extreme psychological distress that constantly being dismissed by healthcare professionals has caused.

> *Shannon: Now that I have diabetes after my recent rapid weight-gain, and I have fibromyalgia and I'm obese. I just know that if I go to the GP for anything that it is not going to be taken seriously because there are three things that they can say: "Ah well, she has not actually got a problem, she's just making it up because she's obese, she's got fibromyalgia, she's got diabetes, let's not investigate this". I think that if obesity were treated in a serious manner, rather than just posting photos on articles of peoples' mid-sections while they are holding hamburgers. If it were viewed as a medical condition that needed treatment, it would not only change healthcare professional's stigma, but perhaps begin to un-pick that wider society stigma as well.*

Interviewer: And, I mean what is it like when you've gone to a health professional and you've said you are suffering with a health condition and it's, does it always come back to weight? How do those conversations go?

Shannon: Always, always. And it makes you- so I don't go to the GP when something is wrong. Unless, like, I had pneumonia earlier this year and I kind of had to go for that. But it makes you disengage with healthcare professionals, which makes your health prospects worse, which turns into a vicious cycle. And, yeah. If you start off with a depressive mind frame as I have, it makes you feel like you are unworthy of care. And once you get to the idea that you are not worthy of care then, it's a very small progression to go, you are not worthy of life. Why even try, you might as well just go kill yourself. So, it's little things like having your weight brought up during GP appointments can have a snowball effect to suicide ideation. It's quite a disempowering, depressing and disheartening experience.

As discussed in the introduction, arguments in favour of disease designation of obesity are often linked to the idea that it would reduce weight stigma. Discussions about "disease designation of obesity" illuminated feelings of ambivalence concerning this. There was concern that disease designation may not be accepted by the public, or that it may even be seen by the public as an excuse and thus it would not reduce stigma. Catherine was also pessimistic about disease designation releasing more funding for weight difficulties into the NHS.

Catherine: Admittedly, I do sit on the fence, strangely enough, because, yeah, as far as the official definition of a disease being that it does mess with the function of your body, then yes, when you are obese it does mess up your whole body, your whole endocrine system, your whole metabolic system, your organs. So, from that point of view, yes, it is a disease. I disagree with the fact that by making it a disease it will reduce the stigma. I don't think that will make any difference at all. I don't think recognising it as a disease will reduce more funding for it, because obese people still do get treatment now. I mean the NHS is on its knees, bless it. So, you know, I can't see how making it a disease will release more funding because the pot is already greatly

diminished, and I don't think it will make any difference to the general public. That they will treat people with obesity just now because it has been classified as a disease. I don't think it will make any difference in peoples' perceptions of it. They will still have their ingrained ideas and opinions. I don't know how you go about changing that, I really don't. It is so ingrained!

3.4.3 Subtheme 3: Validation and Legitimacy is needed

Experiences informed how participants conceptualised obesity and how they engaged with the idea of obesity being designated as a disease.

There was a sense that validation is lacking, and that disease designation could provide some legitimacy and validation. Participants said that they often faced the need to prove themselves worthy of care and that external validation of their needs is lacking.

Catherine spoke of seeing this lack of validation at the highest levels of government.

Catherine: I mean, I was in parliament as part of [organization name] and we were sitting with [name of senior politician in ruling party]. He just didn't get it and we were sitting in a room with obesity specialists and they were presenting the evidence and he just, he was so blasé about it and could not really care less, he was not really listening to us, wasn't taking on board what we were saying.

There was a sense throughout the interviews, that "disease" may not be the most helpful term in describing difficulties with weight, however; a medicalised understanding was seen as something that could act as a defense against blame and stigma, perhaps providing some of the legitimacy that was felt to be needed. While Lisa did not feel "disease" was the most helpful word to use, she did feel it could legitimise access to care.

Lisa: I think it's good to get it officially recognised, because until people do realise this is a disease- I will say disease for want of a better word. It's not a disease, it is symptom of a problem. Unfortunately, food is a mechanism for coping, but so is drug taking. People take drugs because they are trying to run away from something initially. And food does the same thing, it fills a gap, it fills a need that they can't get met

somewhere else, so yeah, I quite agree, get it out there, get it recognised as an official disease, for want of a better word, and get the proper help out there, get it properly funded and get the proper help.

For Jenny, there was no question about the disease status of weight-based difficulties. Jenny attributed her difficulties with her weight to serious medical problems she has experiences throughout her life, and the disease label enables this to be captured. Again, medicalisation provides a defense against the idea of her being "greedy" and helps situate her weight in the context of her health. However, Jenny's experience does suggest a binary way of understanding weight-based difficulties.

Jenny: I have heard it. Yes, it is. Course it is. Particularly now I realise it was the result of the anti-biotics that started the whole thing off in the first place. I mean, you know, I've told you I have binged many times. But then that I think is a result of the candida and your body screaming for the food. It's not "Oh, I'm going to be greedy and I'm going to stuff this lot of food down me".

3.5 Theme 3: The Social Function of Weight

The experience of being a scapegoat, or of one holding a function within groups or society was pronounced. Participants are acutely aware that their body size holds meaning to those around them. People of a higher weight hold a function in society which is experienced by several participants in this study as being a person who holds emotions such as fear, disgust, and a sense of lacking control. Social construction of fat, as discussed, is one of disgust, loathing, laziness, and stupidity, to name a few. Many participants are acutely aware that because of their weight, they hold these emotions for others. This may go some way towards explaining stigma.

3.5.1 Subtheme 1: "Holding a great weight"- The Social Representation of weight

The idea of "holding a great weight", the weight of other people's emotions and their need to project such emotions was very clearly and explicitly expressed by Liz. The experience of this leaving her feeling attacked follows similar lines as the experience of being attacked, abused, and humiliated and the on-going social acceptability of abusing obese people. Given what Liz discussed as her life-long battle with weight and her body, we see these attacks from others being replicated by one's self, through dieting and extreme measures to lose weight.

> *Liz: And they can project all their lack of control onto us. All their fear of being hideous as a person or as a body, they project it all. And you feel it, you are a target. And that's why feeling attacked has been my biggest experience in my life really. Or being attacked, you get so sensitive to it that you actually know.*
> *Fear of fat. It's about being out of control. People don't want to be out of control, they want to feel that they are in control of their lives. They would rather follow the illusion that they are in control of their lives, because, that's better than nothing. And most of us are not very much in control of our lives, we're certainly not in control of our fate and when we die and all of that, not very much. But fat people represent to others, this loss of control which they think it is. They don't know the complexity of the problem, at all. Not interested in it, just see the person as out of control. And, and so you get dumped with all these projections on the rest of society, expressed in many different ways, many different ways. Some of them subtle where people don't even know they are doing it, and sometimes absolutely blatant and they still get away with it.*

In her university friendship group, Rachel felt she played at role in her group of friends. Being the "big girl", meant she held other people's fears about weight and body image. She represented what her friends feared- being large. It was implied that this would make one less attractive. By being large, Rachel's friends felt better about their own bodies. Thus, leaving Rachel holding the emotional connotations of fat.

> *Rachel: Well, I remember in regards to university where one of them once said to me, she was a bit drunk. She was very slim, but she had body dysmorphia. She once said to me: "I love going out with you because I know when you're there I know I'm not the biggest girl in the room".*

Interviewer: Oh my god.

Rachel: I think I was probably about a size eighteen. She was probably about a size ten, but you know she thought she was a lot bigger. And I remember thinking; "Oh my god, I just serve a purpose". And even things like when one of the girls would say: "I feel so fat today, I just want to lie around in big baggy clothes, Rachel can I borrow something"?

Rachel did resist this where she could, refusing to be forced into this position in the best way she could. By denying her friends the role they wanted her to fulfil, she attempted to create an alternative role for herself in relationships.

Rachel: I remember reading something that said: "People are more likely to put on weight if they have overweight friends". I remember reading this twenty years ago and thinking: "I will never be the friend that my friends can sit and eat crap with ". I remember thinking; "I never want to be the friend that they go out clubbing with some friends and when they feel like a night in with a pizza and a DVD, they come to me". So, I always, I would never be the person that suggested burgers, I would never be the person suggesting takeaways. I would never be the one going: "Come on guys, just one more drink". Or "let's have desert". Whenever I would go around to peoples' houses, I would take a bottle of wine, I wouldn't take chocolate or naughty things. I've always made a very conscious decision to not have food as a thing.

However, a double bind appears to emerge, when participants did speak of losing weight, they then noticed even more scrutiny which was presented as worry from others; a worry they may be getting too thin or damaging their health. This was interpreted as a challenge to others, as they could no longer locate painful emotions in the person who had previously been of a higher weight.

While going through the process of losing weight; Catherine was highly aware of the reaction of others around her, to such an extent that she attributes her weight re-gain in part to this experience.

Catherine: But even that I was still borderline obese, people were still telling me then to stop losing weight. And again, I wasn't expecting that.

Interviewer: What was your response to that, what did you think about that?

> *Catherine: I think partly because I was embarrassing them, I was looking fitter and healthier than they were. And they didn't like that because it showed up their- because when I was big, they could relax. As soon as I started losing weight and looking really good and starting to live life and do all the stuff that I wanted to do, I think maybe people were jealous or envious. Whether it's, yeah. That was part of the reason I took my foot off the gas and the weight started creeping back on again.*

Emma spoke of reactions she received from others following her bariatric surgery which meant she could only eat very small portions of food.

> *Interviewer: How did people respond to you then, was there a difference in pre and post-surgery?*
>
> *Emma: I was absolutely crazy. Everyone thought I was crazy having the surgery and then afterwards, now. People still worry for me. It's like they don't- "Is that what you can eat? Oh! Are you not eating anything else? Surely you can eat more?" And can't understand that I physically cannot fit large amounts in, and they are worried for me. People worry that I don't eat large amounts. I'm absolutely fine. I'm very healthy. I'm perfectly fine and healthy, don't worry about me! So, when we go to a restaurant, people feel upset that I'm not eating large amounts, the same as they are.*
>
> *Interviewer: Why do you think they are upset?*
>
> *Emma: I think it makes them feel guilty. I think they feel they are shoveling in huge amounts of food and enjoying their food. And they look at me with a tiny little starter and they kind of maybe think in the back of their minds: "Maybe I should only be having a tiny amount of food, but I love it and I'm going to shovel it in any way!" So, I make people feel guilty!*

The idea of morality was present in several of the interviews. Higher than "average" weight has moral connotations and the internalisation of this is present in narrations of experience. The obligation to take up less space could be described as a moral one, in Rachel's account

of her own use of public transport when she was bigger, and that of others. The way in which people take up space was influenced by the messages they take on. There is a silent expectation to become small, to shrink the body, to shrink oneself. And if one cannot do that, there are behaviours one must abide to, to reduce inconvenience for others, who might be offended by a larger body. The fact that a larger person may need more space is not seen legitimate, like it may for people with other needs. Higher weight thus is understood as an impingement on others, a larger person's need for more space, is unacceptable, just as larger people are unacceptable.

> *Rachel: -their fat is now impacting on other people. Their inability to keep their weight under control now means they are taking two seats up. Now, if I was big, I didn't sit down. If thought I wasn't going to be able to contain myself in one seat, I didn't sit down. I made sure I stood up. So, you see it. And I see it in peoples' eyes, when look at them, and that person in spread out and they are not making any attempt to—if I was sitting on those seats I would make an attempt to keep myself as tiny as possible and then pull my coat around me tightly. And when you see someone who just lets it all hang out and just takes over those two seats, I don't think anybody thinks: "Oh but they've got a disease".*

The idea of disease designation is also associated with public sympathy. Disease designation is seen as alternative to the status-quo; a situation where people of a higher weight are treated extremely poorly. It is perhaps an alternative to the dominant idea that weight is a matter of individual responsibility and control.

> *Rachel: I don't think there is much sympathy in the population. People will think—and I know there are people who are on a medication that makes them put on weight, and every sympathy to them. But, if we go for the majority, I think most people don't have sympathy for seeing someone overweight, eating a box of chips and then saying: "I've got a disease".*
>
> *Interviewer: So, what do you—how do you think the public kind of, react. Or how do you think that would impact public perception.*
>
> *Rachel: What calling it a disease?*

Interviewer: Yeah.

Rachel: I don't think the public are very sympathetic. I really don't.

3.6 Theme 4: Making sense of weight-based difficulties through dominant conceptualisations

Participants generally spoke in complex terms about their ideas about why people gain weight. Most participants spoke of their frustration about the mantra of: "Eat less, move more", which is sold as the answer to their difficulties with weight, by friends, the media and healthcare professionals. Participants were articulate in expressing their experiences; the complex range of factors; psychological, relational, social, biological that had led them to have difficulties with weight. Many spoke of a need for weight-based difficulties to be understood in much more complex terms by society, and a need to move away from individualistic and blaming approaches to weight.

Despite this, it was striking throughout the interviews that participants tended to move back and forward between individualistic and systems-based understandings of weight. This has implications for how people who have difficulties with their weight, experience their weight, as well as how they incorporate the "obesity as a disease debate" into how they make sense of their own lived experience of being a higher weight, as well as how they view others.

3.6.1 Subtheme 1: Moving between conceptualisations of obesity

It was observable throughout interviews that participants held differing conceptualisations about obesity simultaneously. As discussed in pervious themes, there is complexity underlying participants reasons for developing difficulties with weight. These reasons are expressed both explicitly and implicitly and are woven through peoples' stories. It was also clear that the continual abuse, stigma, and messages about higher weight being "wrong" taken on and internalised, influence how one views oneself, how one lives life, navigates space and relationships. The moves between making sense of weight-based difficulties, rather than staying with complexity likely represents the huge pressure people feel to

conform, not only in body size, but in how they account for their body size. Given the level of abuse participants have experienced, adhering to individualised accounts may protect from further experiences of being undermined. Again, placing them in yet another double bind. For anything to change, society must change how it views difficulties with weight. It may be very risky for obese people to publicly challenge the status quo, given the level of abuse they regularly experience. This also demonstrates how dualistic debates regarding body weight are, there often exists little space for nuance.

Discussions about weight are tied up in neo-liberal politics, which currently transcend many aspects of live in the UK. This is essential to acknowledge as it will inform how participants talk about and make sense of experiences, but also how they experience the world around them as larger people, or as people whose weight has changed significantly.

It is important to mention while this theme was observable in most participants' accounts, it was not the case for everybody, thus some attention will be given to these participants, also, and their conceptualisations of weight-based difficulties.

Rachel incorporated issues such as poverty and disability in how she made sense of obesity in the wider context, however, individualistic explanations were also play with respect to where she thought change needs to occur.

> *Rachel: And there are so many factors, I get it. I get the chicken shops on every corner and under-educated parents with more than one kid, potentially kids with learning disabilities or special needs and they don't have a lot of support, I can understand that they give them a packet of crisps at 8am just to shut them up. I understand that it is more complicated than it looks.*
>
> *But, I would say from what I've personally experienced and what I've seen. If people move more, and they eat less they tend to be able to lose weight at a steady rate and keep it off. So, I'm not sure what labelling this as a disease does for it.*

Tina spoke about what it was like for her when meeting a psychologist whilst attending an NHS weight loss programme. For her, this support helped her to make sense of the psychological factors influencing her eating habits and was ultimately a helpful experience for her.

Later in the interview, on reflecting on her role as a nurse working with young people and families, she took on a slightly more individualised narrative in how she conceptualises difficulties with weight, its causation, and what this then means for disease designation, in her view.

> *Tina: I think for me, the clinical psychologist in the tier three was quite -um- challenging. And I don't think we are challenged as adults. So, we kind of looked at behaviours, patterns, emotional eating. That kind of thing. Things we do all the time that don't actually take into consideration of the motivation of that is for. And I have to say the first couple of proper sessions with her, I came away thinking- I wasn't very impressed, I was quite disgruntled. [laughs]. She was really challenging! But actually, the more I reflected on it, it was absolutely the right thing, because when you're an adult nobody does challenge you. When you're a child you've got someone say to you: "Do you really think you need that fourth kit-kat?". We don't do it as adults. So, actually some of the behaviours I was doing, I hadn't even considered they weren't particularly helpful, so.*
>
> *Interviewer: Sounds like it helped you to think about what was going on for you beyond the numbers game, of take the medication and lose weight, or whatever.*
>
> *Tina: This is it, you can teach most people about calorie input and exercise, but yeah, it's the other stuff.*

Later Tina stated:

> *Tina: I work with families where you can see where the issues are. You can see it comes from parents and parents almost colluding with the children. And so, yeah. I really don't know where I sit. I don't think I believe it's an illness, if you like.*
>
> *I do really struggle with it. I think I worry that if it's kind of- people will become less proactive in doing anything about it if they think it's an illness that they've got no control over. I don't know.*

For Lisa, a conflict emerged between her sense of weight being an issue of personal responsibility and how people gain weight for all sorts of reasons.

Lisa: *We are not any good at taking responsibility for ourselves, I don't think. We are happy to plod along and get something because it is easy, rather than using your brain and think about what you are having. Putting a meal plan together, I know there are hidden disabilities and psychologically there's barriers, but we do need to take responsibility for ourselves.*

Emma expressed how despite her own experience of discrimination and judgement for her size, the extent she took on negative messages about fat, directly influence how she saw and treated other obese people. Emma's story demonstrates how associations with higher weight become internalised and determine our view of ourselves and others. It is very difficult to dissociate from these messages, even when our logic tells us so.

Emma: I can remember we did some interviews for a management position. And bearing in mind I was twenty stone. We had three or four people came for the manager's job and there was a woman who came who was very good and really well qualified, but she was bigger than me. And I said to the girl who was interviewing with me: "We can't have her, she's huge. She's huge! I don't want her representing my business. She's not the face of my business. I'm not going to have her as a manager representing my business, she's just too fat". And she really laughed and went: "You're so fatist, but you are fat!" And I'm going: "Well I know, but I'm not on the shop floor. I do not want her as the face of my business. I just don't".

Emma felt that her weight was less of a problem for her business image as her role does not involve meeting customers. Her worry was about what customers might think of her business, what reputational damage might occur should a person of a higher weight represent the business to customers. The idea that Emma feared a manager's body size could damage the reputation of a business is a stark example of the level of discrimination and judgement that obese people experience, as well as how powerful the internalisation of weight stigma can be.

3.6.2 Subtheme 2: Where experience meets the medicalisation debate

The obesity as a disease debate reflects a binary approach to how we understand weight-

based difficulties, individually and societally. The experiences and explanations accounted in this study demonstrate this. There is a tendency for difficulties with weight to be thought of either the individual's fault or not. The discussion about obesity seems to leave little space for nuance and complexity. The obesity as a disease debate, in some ways reflects this. The ambivalence present in the interviews about whether or not the UK should official designate obesity as a disease may represent a sense among participants, that there is a need address weight-based difficulties, weight stigma and access to healthcare, however disease designation is unlikely to do this, and may even distract from what participants feel is the real issue.

Shannon represents this by positioning the debate as a choice; if it is a disease; I am being told I am not to blame, if it is not a disease then the opposite is true. Shannon's perspective also highlights the issue of prevention, which may feel like an important and overlooked part of our discussion. The ambivalence Shannon feels about the debate is noticeable, the debate feels removed from her experience and what matters most to her; which is to alleviate suffering for herself and others living with difficulties with weight and to be treated with compassion and respect by healthcare professionals.

> *Shannon: I think that's [the debate] a distraction from the real problem of; let's make it so that people don't have to live with obesity. If we are putting it as a life-style choice versus long-term condition or disease, then I would certainly put it into the long-term condition/disease category rather than lifestyle choice.*

Later Shannon said:

> *I think if it were classified as a disease that there would be an onus on healthcare professionals to see something to treat, rather than a person who is flawed. So, I can see the benefit to it.*

It is interesting that Shannon speaks in terms of putting an onus on healthcare professionals to change, rather than expecting it to happen through training and supporting professionals to engage with the literature on weight stigma. Again, this may speak to her repeated experiences of being dismissed and a sense of hopelessness that change is possible.

Liz aligned her conceptualization of obesity in the terms of a disability and addiction. This is perhaps a way of emphasising the distress that she experienced and continues to experience in relation to her weight and the responses it elicits from others. The idea of food being an addiction attempts to give some context to why food might become an issue for people, in a way that many might understand that alcohol addiction may have started as a way of coping. There is frustration and anger in Liz's account that is rooted in the powerlessness that people of a higher weight feel through years of being ignored and maltreated.

> *Liz: I'm addicted to sugar! The government hasn't even recognised about the addictive quality of sugar and how dangerous it is for some people, just like alcohol is for others. They haven't recognised it; they refuse to recognise it because our economy is based on it. And they are just not recognizing it. People believe them, they don't understand, this is a terrible addition -uh- addictive substance for some people. And that's what I have combined with all the other factors in my physiology. The other thing I'd like to say. You asked: "What is a weight problem to you?" and I wrote down straight away: "A life-long curse". And the second thing I wrote down was: "A very serious chronic disability on many levels, especially socially and psychologically".*

Jenny's account also suggests what it might mean for difficulties with weight to be labelled a disease. Her idea of what this is concerned with is rooted in public understanding of obesity, rather than technicalities of what can or cannot be defined as a disease. Similarly, to Liz, she speaks of using food in a way, like an addiction, something that helps her to manage painful emotions. Distress brings about feelings of hunger, which she responds to by eating. But this is a vicious cycle as it often leaves her feeling worse about herself. Jenny's account does not give us an understanding of how different conceptualisations relate to her experience. This may reflect what Shannon said about the debate and not feeling as though it addresses the most important issues for people.

> *Jenny: -you see, I think it's the same thing. I don't think people would really treat it that way. Whatever, whether it's diagnosed. They just think it is being, you know: "You're just being nice to people. You know prisoners are awful people but the people*

who want to treat them nicely? Oh, come on, they have done bad things". It's that sort of attitude.

Interviewer: So, people would accept it on surface level, but actually it wouldn't be meaningful?

Jenny: I doubt if they'd even accept it on the surface.

Interviewer: Right.

Jenny: If you're fat, you are greedy. You are stupid too. And I realise to some extent, when you binge on carbs, it has a similar affect as I have seen with family members and alcohol. It sedates you. That's one of the reasons I would do it. I would get really upset about something, I'd never face what I was upset about, so I would just start feeling hungry. And that was, so I didn't have to face that I was upset. And I'd eat until actually I didn't think any more. It definitely does have that affect.

Jenny's comparison of prisoners and people of a higher weight points to the moralistic associations which are very frequently made. For Jenny, no amount of science or discussion could convince people otherwise.

Tina was clear that she did not feel a disease label was appropriate for difficulties with weight. However, her understanding of disease designation was similar to others as it was rooted in ideas of fault, blame and responsibility. Her response to the question of: "Is obesity a disease?" indicated that she felt disease designation would enable people to dis-engage with their health.

Interestingly, Tina's medical team are curious as to understand biological factors that may be contributing to her weight gain; however, she maintains a position that her weight has a behavioral cause and thus is a matter of action and activity. For Tina, her weight is an issue that she feels she can resolve through the choices she makes.

Interviewer: I guess, one of the things I am speaking about to people. Is the question that's out there at the moment about whether or not we should designate obesity as a disease. Have you come across that?

Tina: Yeah. There's a Facebook group -um I'm trying to think what it is- there has certainly been a lot more on social media about that. And also, in the news as well. I don't know. I don't know where I sit with that.

Interviewer: Yeah.

Tina: It's not something, I suppose having been overweight for a very, very long time, I have always seen it as -um- my responsibility. I have never ever felt that it's a kind on illness or anything. Or that it is something I was born with. So, no I don't know.

Interviewer: It sounds like maybe for you it feels like you can control it if you choose to? Or if you are able to at a particular point?

Tina, Yeah. And this is it. That's not the message I always get from health providers. And certainly, my husband said the same to me. He has said he is convinced that there is something underlying, that there is clinical reasons. And I have felt that I am like I am- because over the years I have eaten too much. Where I'm at the moment, in terms of- I saw my consultant at [name of hospital] only just before I went away on holiday. And he has referred me for a metabolic study because he is convinced, I have a very low metabolic rate. And this is it- I still- yes that would make sense. But I suppose over the years you hear people say stuff like: "I've got a really low metabolism". You think: "nah". I've always seen it as people making excuses and not wanting to take responsibility for how they are. Because at the end of the day none of us are born obese.

CHAPTER 4: DISCUSSION

This chapter provides a summary of the findings in relation to the research questions. Psychological theories that support making sense of the findings will be explored. Clinical, policy and research implications will be discussed. A critical review of this project is discussed and suggestions for further research are made.

4.1 Summary of the findings

The study aimed to explore the lived experience of obesity among people who have accessed NHS weight loss services. Interview data was analysed using IPA and four superordinate themes were developed. In exploring the lived experience of weight-based

difficulties, this study found, in line with previous research, that people experience significant de-humanisation, stigmatisation, and objectification. These messages are internalised and impact on people's self-image and how they relate to others. While participants had a sense that there were complex experiences or events that led to weight becoming a problem for them, it was difficult for them to hold onto this complexity and instead they tended to rely on dominant social framings of weight-based difficulties. i.e. that it is either a medical issue or a moral failing. The idea that there was a social function to weight was found. Participant's spoke of a strong sense that their body weight was a symbol of anxiety concerning lack of control, others' poor self- image and people's guilt and anxiety about needing to monitor their own behavior, particularly in relation to eating. The participants expressed that they held and internalised these feelings from others. An exploration of participant's ideas concerning the "obesity as a disease" debate, highlighted ambivalence about the move towards increasing medicalisation. What participants highlighted as being important to them was a change in how they are treated and legitimisation of their difficulties and distress. Participants did not feel convinced that disease designation could provide this.

4.2 Discussion of the Findings

4.2.1 The embodied experience of being of a higher weight

Participants spoke in detail about their lived experience of having difficulties with weight. Interestingly, the internalised experience and its meaning remains with people even when their body size reduces drastically. People internalise their experiences of weight-based stigma and this has a significant impact on their sense of self. The internalisation of weight stigma appears to have negative consequences for the peoples' health. A study by Pearl et al., (2020) found that internalised weight bias as opposed to experienced external weight bias has significant adverse impacts on health outcomes. It also increases the likelihood of weight gain. The internalisation of obesity stigma results in not simply behavioural changes or restrictions, but relational impacts. In prioritising of accounts of weight-based difficulties that are concerned with morals or control, a subtle denial of the experiences of events that

led to them gaining weight occurred.

The sub-theme “Shame, de-humanisation and feeling exposed” detailed a continual feeling of being exposed and under scrutiny from others. As it occurred so regularly, the experience of being de-humanised came to be expected for some of the participants. This reflects some of the existing literature discussed that people with obesity experience repeated humiliation and de-humanisation across a range of contexts, including during the course of un-related healthcare treatment (Furber & McGowan, 2011; Merrill & Grassley, 2008). The internalised representation of obesity in turn became a despised aspect of the self and a source of shame. When Emma spoke about dating since having lost weight, she spoke of going to extremes to ensure the person she was dating did not find out about her bariatric surgery. She did this by obscuring the amount of food she ate to avoid her date asking questions about her eating. She expressed a fear that if the date knew about her surgery, her true self- “a fat person disguised as a thin person” would be revealed, making her unacceptable. Emma’s comment seems to suggest something that goes beyond physical appearance or size. Size becomes a representation of worth and deservedness of intimacy, sex, or a loving relationship. Haga, et al., (2020) found that people with obesity often feel as though their life is on hold. They cannot live life the way they want until they are a socially acceptable size. The issues of worthiness raised in this study may reflect this. As larger people feel unworthy of care or intimacy, forming new relationships may be put on hold, or seen as less possible for them while they remain at a higher weight. For Emma, the feeling she might get found out suggests that at a larger size, dating may not have felt like an option.

Merleau-Ponty draws on the idea of a phantom limb to describe the gap between the objective body and the experience of the body. Amputees may report pain or sensation in the limb that has been amputated, the phantom limb becomes an expression of the body as it used to be (Merleau-Ponty, 1962). There are similarities here with Emma’s experience, as her body image is based on her experience of her body as it used to be rather than how it is now.

A similar experience was reflected by Liz who defined her fluctuating weight as a representation of her inability to be a reliable partner to a man. For Liz, being of a higher weight represented something about herself that went beyond her appearance. Liz’s weight

is a signal to others that she is in some way deficient or less than as a person than if she were a “normal” weight.

4.2.2 Making sense of weight-based difficulties

Participants spoke of how they come to understand obesity through their lived experiences. As highlighted, there is a tendency for the debates concerning obesity to become binary, where difficulties with weight are either framed as a medical issue or a moral failing. In examining the lived experience of participants, it was possible to see how these dualities emerged in the language people chose to speak about their experiences. The theme ‘making sense of weight through dominant conceptualisations’ highlights the sometimes-conflicting language and explanations people used to describe their difficulties. In the telling of their stories, participants spoke of traumas, distress, and significant life events that they felt explained why weight became a difficulty for them and why it continued to be so. Reflecting a finding by Ueland, (2019) that people are aware of how, why, and when weight began to become a problem, with it often being linked to early relational experiences. Some spoke of painful and difficult family relationships, health problems in early life and disruptive events. These experiences were clearly recalled, and it seemed that participants had spent much time considering and thinking about why their weight had become a difficulty. There was a level of introspection that perhaps most people do not commonly give to their experiences. This may reflect a need for people to be able to provide an explanation about their bodies. This reflects what Carel, (2011) describes as the transparency of healthy, normal bodies which are taken for granted and their processes rarely thought about. Changes to the body or an illness result in increased focus on bodily processes and movements. The framing of the larger body as an ill body may encourage this increased attention on the body, its perceived flaws and the mental processes that influence problematic eating behaviors.

While people were able to clearly articulate painful and sometimes traumatic experiences and how this led to them using food to survive, this often got lost in the language of individualism. It seemed difficult for people to stay close to their experiences. There was a tendency to minimise those realities in favor of self-blame and expectations that they

should be able to maintain weight loss. An example of this was Jenny, who spoke openly about difficult childhood experiences and health problems that had both psychologically and physically made weight loss very difficult for her. She spoke about the many diets she had been on throughout her life and how these had been damaging for her. However, at the time of the interview she was still using dieting and restriction of some foods. Despite her self-awareness, the pressure to lose weight through dieting continued. Jenny's experience demonstrates how the meanings attributed to weight can be embodied, through following social expectations to restrict and engage in self-control. Jenny's experience reflects earlier findings highlighting the pressure people feel to pursue a thin aesthetic, despite the costs it has to their health (Thomas, et al., 2008).

In some accounts there was a sense that some people were more to blame than others for their weight. Some spoke of their understanding of how socio-economic inequality is linked to increases peoples' body weight, and how difficult it is for families who may be struggling financially. Yet, again it was difficult to prioritise this and there was a feeling that some people really were at fault or to blame.

Despite her own experiences of being stigmatised and discriminated against, and finding this upsetting, Emma spoke about how she herself discriminated against a woman who was being interviewed for a job in her company. This demonstrates how entrenched stigmatised weight representations are. Emma feared that employing a person deemed to be very large would damage her business reputation, such was the extent to her internalised weight stigma. This phenomenon is not just seen concerning the issue of weight. For example, researchers have sought to understand why some women support sexist beliefs. Becker, (2010) found that women who express sexist beliefs were more likely to have internalised these beliefs. Given the extreme weight stigma many of the participants in this study experienced, it is possible that maintaining the socially accepted understandings of weight-based difficulties, acts as a protection against further backlash. Owning responsibility to some degree and working to reduce weight is a sign of deference to a society that values thinness and despises fat.

4.2.3 Medicalisation and disease designation of obesity

This study sought to explore participants' views about the move towards disease designation of obesity through a phenomenological lens. This study was conducted in the backdrop of the on-going debate about whether obesity should be classified as a disease. Participants were generally ambivalent about this and expressed a worry that it would not make any meaningful changes to their experiences of being stigmatised. However, there was a hope that disease designation could provide legitimacy to their difficulties, that it may undermine the prevailing narrative that being obese was their fault and their responsibility. In this sense arguing for medicalisation may be an attempt to resist individualised conceptualisations of weight and health. But medicalisation re-in forces individualism rather than challenging it, thus falling short of what participants seek, which is a move away from blaming and stigmatizing attitudes. In this binary argument, there are few alternative understandings or conceptualisations to draw from. The medicalisation argument poses two options; obesity is a disease, or it is not. This reflects binary understandings of obesity. Being fat is either the person's fault or it is not their fault. Arguably, the prevalent language of individualism and personal responsibility, (Kyle et al., 2016) which very powerfully frames discussions concerning obesity, makes it very difficult for people to draw on alternative ways of thinking about obesity, largely because they are inaccessible in the wider culture. A sense that disease designation could provide legitimacy to their difficulties with weight was expressed. Interestingly, parallels can be drawn between this and a push for the medicalisation of women's sexual pain. Farrell & Cacchioni, (2012) highlight that women experiencing sexual pain were at the forefront of advocating for medicalisation of sexual pain, due to years of being left without adequate diagnosis and support for their problems. The argument for medialisation provided a sense of legitimacy to women who had gone without recognition of their pain and needs for some time. The hope was that a biomedical lens would bring resources and funding to this issue. However, Farrell & Cacchioni, (2012) also highlight the inherent power dynamics within this, most notably the heteronormative ideals used to indicate success concerning treatment for sexual pain. These were almost entirely focused on women's ability to have penetrative sex. This is relevant to the present study, because as it is argued; disease designation of obesity may bring benefits in terms of resources, treatments, and support (Kyle et al., 2016). The Farrell and Cacchoni (2012) study

indicate the way in which these resources are provided may tend to serve dominant social ideals about acceptable outcomes and behaviors. This suggests it is important to ask what might be provided under disease designation and whether they may perpetuate social norms and ideals that currently cause harm.

Attempts to express nuance and complexity were present in participants' accounts. The difficulty in expressing this was, however, marked. Some spoke about food as an addiction and feeling that their difficulties with food were like that of a person experiencing substance addiction. Like findings by Ogden and Clementi (2010), participants in this study spoke of food being used for emotional regulation. Implicit in this is an attempt to convey something of their experience, that there were emotional, psychological, and social factors that led them to this place of difficulty. That food was not the problem, but early experiences and difficult life events combined with biological and genetic factors led them to a point of food becoming a coping mechanism.

Participants spoke about disease designation with respect to whether it could reduce stigmatisation and increase public sympathy. Reducing the stigma associated with obesity is a frequently cited argument in favor of disease designation (Wilding et al., 2019). However, participants generally did not consistently share this view and there was a sense of hopelessness that weight stigma could be reduced societally or that it would make the public more sympathetic towards them. Catherine spoke of being a campaigner for disease designation, but still feeling that it would do little to change how others viewed hers and other's difficulties with weight. There was a marked sense that the public are unwilling to express sympathy. This links to the concept of the sick role (Parsons, 1962) whereby those inhabiting the sick role are expected to engage with medical advice and treatments that seek to improve their health. When people with obesity are deemed not to be doing so- i.e. by not dieting and maintaining a socially unacceptable weight they become positioned as deviant.

Participants tended to engage with the "obesity as a disease" debate through the lens of blame, responsibility, and sympathy. The issue of personal responsibility was woven through the accounts. There appeared to be a tendency to side with or choose a side of the debate and align it with ideas about responsibility. There were differences of opinion expressed, yet there was a similar pattern with respect to the way in which disease designation

represented a diffusion of personal responsibility. Tina was clear that her problems with her weight were her responsibility to resolve through behavioral change. Despite suggestions from her partner and GP that there may be a medical element to her weight worth investigating, she resisted this, feeling that attributing weight problems to metabolic issues is “just an excuse” for a lack of control over her behavior.

Jenny’s comparison of obese people with prisoners underlies the association of high body weight with morality. In comparing disease designation with “just being nice to people”. Jenny compares it with treating prisoners well, as if it is a social and lawful obligation to do so, but that most people are not interested in treating them well because they are deemed to have done something immoral. For Jenny disease designation is meaningless, like a tick box to say society is doing the right thing, but without the intent being present. Again, this points to the hopelessness that people feel about the possibility of being treated kindly, holistically and with understanding.

There were differences of views expressed as to whether obesity should be designated as a disease in the UK, reflecting the wider debate. Those who did not agree with disease designation tended to prefer behavioural modification, public health prevention policy, and education as ways of reducing levels of obesity. While most people had heard about the debate there was a lack of clarity about what this may mean in practice or for services. Some hoped that it may increase resources available for services and underscore the need for support, for example, access to a specialised psychologist or access to Liraglutide which is not currently licensed for weight loss purposes in the NHS, but has been found to be effective in causing safe weight loss in patients (Mehta et al., 2017).

4.3.2 Self-monitoring

The idea that obesity was a representation of being out of control and lack of control was discussed. Most of the participants in this study spoke of life-long and near constant self-governance through multiple attempts to diet, monitor calories and exercise. Self-governance, was also present in how participants spoke of their occupation of space, finding ways to make themselves appear smaller, with dark or loose clothing, minimising the space they take up on transport, etc. In a Foucauldian analysis of “the fat female body” Murray,

(2008) posits that neo-liberal politics plays out in the issue of body size. Individuals must take responsibility for maintaining their health so that they can be economically productive. Additionally, the media encourage women to discipline and regulate their bodies through self-governing behaviours, such as calorie counting, food restriction and specific diets which are often very costly. Women are often the target of the marketisation of self-discipline, and thus it may not be surprising that in this light the issues of control and discipline were present in the data.

4.3.5 The function of weight bias

People of a higher weight are perceived to be lacking in self-governance and control, however the present study found that most obese people engage in numerous periods of dieting across their lives. This is not surprising, given the low long-term maintenance of weight loss (da Luz et al., 2017). Thus, the idea that people with obesity experience high levels of stigma because they lack self-governance does not go far enough in explaining the level of shame and de-humanisation they experience. This study found that there is a social function to obesity that is very strongly felt by the participants in this study. Across the interviews was the idea body weight holds a meaning. People of a higher weight experience the fears of others, often containing and internalising them. Larger bodies represent fears about lack of control, fears about shame rejection and self-disgust.

As discussed in the introduction there is a significant range of research examining the impact of weight stigma on obese people. However, less has been written about the social role concerning the social construction of obesity and the projections obese people experience from others. The feeling that Liz expressed of “holding a great weight” resonates with several of the experiences discussed across the interviews. Larger people internalise and contain painful emotions for others. This was acutely felt and clearly expressed by several of the participants in this study. The stigmatisation of and projection of unpleasant emotions onto large people serves a function. For Rachel, her university friend, whom she described as having problems with her body-image, was relieved to have Rachel accompany her on a night out. This meant Rachel’s friend could lessen her own anxiety about her body

been judged to be too big. Rachel could "be the big girl" positively reinforcing the friend's power and standing within the group. As discussed, being a higher weight is associated with a lack of control, deviance, and immorality. There was a sense from some participants that their presence allowed others permission to "break the rules" and indulge in high calorie food. Both Emma and Catherine spoke about negative experiences of eating out in groups. Catherine spoke about how she felt that her presence as a larger person allowed others to relax about what they ate. If she were present, they felt less guilt about choosing dessert. After her bariatric surgery, Emma noticed friends' discomfort about the small portions she ate when dining out together. Their comparison with her led to discomfort and this was followed by attempts to discourage her from losing more weight, even though she still identified herself as over-weight. Emma reflected that seeing her eat small portions raised feelings of discomfort and self-consciousness in them as they could no longer positively compare themselves to her. In these interactions ideas of control and self-governance are played out. The larger person holds anxiety about a perceived failure to self-discipline. There is an element of permissiveness that arises within this, as if people can, for example, eat the desert because they are in the presence of a larger person. Rachel was very aware of this and resisted this position by making healthy food and drink choices in the company of friends. However, this too restricts her as her choices were determined by this dynamic. She must remain constantly alert to how she is positioned by others, making it very difficult to relax or to make choices in the present moment.

4.3.6 Gender

While it was not a specific theme in the data, it is important to consider gender. All participants were women and there are likely to be intersections between weight and gender that influence experience. Participants spoke of being objectified; their bodies commented on freely by others and their choices undermined. Intrusions upon women's space and their bodies is well documented.

Looking to other areas of research concerning embodiment, health and gender highlights some parallels with the issues raised in this study. Research in pregnancy has examined

issues of female bodily containment and control. Pregnancy may be socially constructed as a time of lack of bodily control or a time where bodily containment is at risk (Davidson, 2001). The idea that women's bodies are at risk of being unruly or uncontrollable is heightened during pregnancy and childbirth. Women experience increased surveillance and an expectation that they will take responsibility for managing their bodily functions. They are held accountable for adverse fetal outcomes, particularly if they are viewed not to be demonstrating adequate control or responsibility (Carter, 2010). It is interesting to look at the parallels between pregnancy and obesity, and the gendered aspect of this. The fear and hatred of the uncontrolled and unruly body was present in participants' accounts of their experiences. Rachel spoke about the disdain she expected to experience if she as a person with obesity took up what others deemed to be "too much" space when travelling on public transport. She reflected on her attempts to make her body as small as possible when sitting on the bus, using her coat to contain her body in case she infringed on a person sitting next to her. The ways in which the female body is subject discipline and control is well documented in feminist literature. Catherine reflected a similar experience; to go about her daily life means always being aware of her body. Larger people hold an awareness of their body that others do not, for example, constantly thinking about the perceptions of others, how to carry herself, how to appear smaller. The monitoring of the body can be framed as an attempt to maintain or gain control of a body that is experienced as being out of control, a body that fails to abide by ideal expressions of femininity. Although, it is important to note that pregnancy is seen as an ideal expression of femininity (Douglas & Michaels, 2004), thus there are limits to comparing research into pregnancy. Nonetheless, issues of bodily containment and control are pertinent.

Gendered experiences were discussed by Emma, a business owner, who at a trade show was assumed to be the assistant to the man who was her employee. The experience of being invisible in a business context was marked. Being a woman and being large are not stereotypically associated with the image of a business owner and thus Emma was ignored by potential business partners until her employee pointed out that she was in fact the owner. This links to ideas expressed about fat people being incompetent, stupid, or lazy. However, Emma felt that her gender played a role in the assumptions made about her.

4.4 Implications

There are several implications for practice and policy based on the findings of this study. These will now be discussed.

4.4.1 Clinical Implications

The present study highlights that internalised weight stigma and experiences of de-humanisation give way to feelings of shame. It is important that healthcare services understand this and that they treat people holistically with an awareness of the impact of weight stigma. This suggests a possible role for clinical psychology in supporting training for a range of healthcare professionals on the issue of weight stigma. Helping healthcare professionals to understand the detrimental impact of weight stigma on obese people's health may support a change in attitudes and responses to weight which could have lasting positive impacts.

Phenomenological approaches to psychological therapy may provide an interesting opportunity for psychologists to engage with issues such as the internalisation of stigma, and the impact of shame and de-humanisation on how obese people make sense of events and experiences. While there is no specific precedent for using phenomenological approaches to therapy with this population, some work has sought to consider how it may be applied in a mental health context. Ratcliffe (2010) offers a phenomenological analysis of guilt in a person experiencing depression arguing that bodily feelings cannot be dis-entangled from emotions. The phenomenological rejection of mind-body dualism allows an examination of depth of emotion and analysis of experience.

van Deursen (2014) outlines the process and techniques for providing phenomenological therapy. As phenomenology is interested in experience, the focus of the therapy is on allowing the client to observe, attend to, and express their experience. In acknowledging that people are limited in understanding their experience through the context available to us, this approach acknowledges this and allows for new perspectives to be invited in (van Deursen, 2014). Given the internalisation of weight stigma described in this study, one can

imagine that larger people experience themselves through this lens. Allowing new perspectives, particularly those that may not align with dominant conceptualisations of obesity may be helpful in breaking down negative self-perceptions.

4.4.2 Implications for policy

This study sought understand people's lived experience of obesity. As experience is informed by the social context, the current debate regarding "obesity as a disease" was explored in relation to participants' experience. The present study highlights the ambivalence felt, suggesting that NHS service users do not have confidence that adopting disease designation in the UK would significantly improve their experience of stigmatisation. Participants felt that stigmatisation of larger people is so socially ingrained and reinforced that shifts in public opinion would be difficult to attain, including in healthcare settings. Given the detrimental impact of weight stigma on health, policy should focus on ways for this to be targeted; both in healthcare and in the wider society. This study suggests that disease designation of obesity, alone, is unlikely to achieve this.

There is a desire to move to a more nuanced approach to the debate concerning obesity. However, due to the language and framing of the issue of obesity where personal responsibility and morality often take front and center, this can be difficult. As discussed, participants indicate an understanding of their difficulties with weight as being rooted in a range of different experiences, psychological, biological, and genetic factors. Yet, this is often difficult to articulate, and participants tended to move between dominant ideas concerning obesity causation, even when these ideas appeared to contradict one another. It may reflect the restrictions larger people feel in terms of expressing their experience, which is often dismissed in favor of more socially popular explanations.

This suggests a role for clinical psychologists to be involved in influencing policy, consultancy, and training in this domain. Clinical psychologists are well placed to consider the impact of weight stigma, shame, and dehumanisation on individuals and how they engage with services. The BPS obesity task force (BPS, 2019) highlighted that clinical psychologists should play a role in developing healthcare practitioners' knowledge and

understanding of weight stigma and its consequences. However, the role of clinical psychologists can go beyond this, towards challenging public perceptions of obesity through policy and media consultation.

4.4.3 Implications for further research

4.4.3.1 Wider understanding of patient perspective on obesity as a disease

The present study highlighted some of the nuances of the debate as well as some of the problems that arise with framing this discussion in a binary manner. Nonetheless it would be useful to gain an understanding of service user opinion on a wider scale, for example through conducting a quantitative survey of a large sample of people who have accessed NHS weight loss services. Similar projects have been conducted in the USA (Puhl & Liu, 2015). However, one from the point of view of NHS patients may be particularly useful as it would enable a greater understanding of NHS service-users' perspectives and needs. It would also help to ensure that service-users are included in the debate as disease designation is likely to impact on the care they receive from the NHS.

4.4.3.2 Social function of obesity

This study indicates that some people with obesity internalise and contain other's emotions in relation to weight, control, and self-image. There is a body of research that deals with the impact of weight stigma on people with obesity, of which this study adds to. However, less is known about what has been identified in this study as the "social function of obesity". The way in which people relate to people with obesity is likely to impact on whether they treat them in a stigmatized manner or not. The relational aspects of weight stigma would add valuable insights to our current understandings of weight stigma. It is possible that a psychodynamic approach would be particularly valuable with respect to examining projections and defenses that arise.

4.5 Dissemination

As the OEN supported recruitment of this project and are key stakeholders, they will be provided with a copy of this report in addition to a short version, which will be possible for them to circulate to members if they wish. Participants will be offered a copy of this thesis and any future publications.

The findings of this project will be presented to clinicians in the bariatric surgery services where the researcher is currently on placement. Opportunities for the clinicians to ask questions and provide feedback will be invited.

It is intended that this project will be written up for dissemination in an academic journal. Work on this will commence following the final submission of the project to UEL. Should this study be accepted for publication a press release will be written and sent to relevant media outlets. If we wish to see a change in attitudes towards people with obesity in the UK, it is vital that research concerning the impact of weight stigma is available to the public. An effective way to achieve this is through the media.

4.6 Critical Evaluation and Limitations

In this section, the limitations of the study and its quality will be discussed. The way in which quality of this project was ensure will be discussed as will limitations of the study and how these might be addressed.

4.6.1 Quality issues in Qualitative Research

The guidance set out by Yardely (2011) for good standards of qualitative research was utilized to ensure the quality of this study. This guidance attempts to provide a basis for

analyzing the quality of research. Yardley clearly, comprehensively, and accessibly outlines her standards for good qualitative research.

4.6.2 Sensitivity to Context

From the beginning of this project sensitivity to the context was prioritised. Engagement with the literature, particularly that which concerns weight stigma supported an understanding of issues faced by this population and allowed for thought about how to approach the study in a way that would allow the researcher to engage meaningfully with participants' accounts. IPA was chosen to enable access to the delicacy of people's stories and experiences. An understanding of the complexity of the issue was sought, through literature and discussions with supervisors. This meant that asking people to discuss what is a very binary debate (obesity as a disease) did not leave people in a position where they could not freely express their stories and the nuances within. IPA was deemed an appropriate approach to enable access to the subtleties of peoples' experiences, the debate regarding obesity as a disease, and crucially how peoples' lived experience informs how they engaged dominant conceptualizations of obesity.

I was aware that a lack of experience in working in NHS weight loss services may mean I was likely to misunderstand or be unable to fully appreciate the importance of some experiences. Thus, I decided to undertake a speciality elective placement at a London bariatric surgery service. This experience was key in supporting me to develop sensitivity to context. It allowed me to develop my understanding of NHS weight loss services from the point of view of a clinician and see the types of issues that participants may have faced. It also allowed me to engage with a range of professional colleagues on the issues they see pertinent to the area and to see the debate occurring in a clinical context. The decision to undertake a clinical role in Bariatric surgery was invaluable in supporting my understanding of NHS weight loss service provision, the process people go thought to access services and the experiences and needs they present with.

4.6.3 Commitment and rigour

This study was undertaken over a two-year period as part of my Doctorate in clinical psychology. Over this time, I have developed a strong interest in clinical health psychology and as discussed sought out opportunities to develop this interest and increase skills through academic and clinical work. The time allocated to the completion of this study enabled careful thought and time to consider the project, re-visiting areas when necessary.

How and where to recruit was considered alongside the academic and field supervisors. When potential participants came forward time was taken to ensure they were clear on what the purpose of the study was for and what would be involved. I offered telephone calls to interested participants to discuss this, which one person requested. Commitment to the participants was demonstrated through flexibility in timing and mode of interview. Skype and telephone were favoured by participants and this was offered to reduce the time investment they would need to make. As travel may be difficult for people for a few reasons, for example, cost, physical health, experiences of public abuse due to weight, flexibility was prioritised.

Rigour was demonstrated in several ways, including through the scoping review set out. Where needed support was sought from the supervisors of this project to ensure rigour.

Analysis of the data closely followed that set out in the literature, such as that of Smith, et al. (2009). I attempted to provide an interpretation of the data, rather than a description while maintaining closeness to the data. Again, supervisory support supported me to challenge assumptions and biases.

4.6.4 Transparency and coherence

Reflexivity supports transparency in qualitative research. It does this by outlining the researcher's experiences and reasons for choosing to undertake a project on a topic. A reflexivity account is provided below (p.78).

To ensure transparency of process, a comprehensive description of the methodological process this project followed was outlined in chapter 2.

4.6.5 Impact and importance

I chose to undertake this study because of what I felt was a significant gap in the debate concerning obesity as a disease, i.e. the lack of service-user voices within the research. I also came to this project with a curiosity to as to the experiences of obese people, who experience discrimination in many aspects of their lives. This project aims to begin to address these issues. Thus, the dissemination of this project is particularly important so that the impact can be felt and to give voice to the people who have participated. The interview data clearly shows that obese people are excluded, silenced, and shamed. This project is an attempt to resist that and to bring forth the voices of key stakeholders in this issue

4.6.6 Recruitment

Recruitment was via the Obesity Empowerment Network, an advocacy organization for people living with obesity. Through their contact with OEN, it is likely participants have had some prior engagement with the issues raised in this study. Thus, it may be useful for any future studies to recruit from a wider range of sources as this may yield differing results.

Criteria for participation required some contact with NHS weight loss services. This was to capture the NHS context, but also as kept wide enough to elicit a wide range of experiences. While some participants had undergone bariatric surgery, not all had, thus widening the range of experiences. Participants were asked about the services they accessed; however, they were not asked specific details about their weight or weight history. One potential limitation of this is that we do not know if prolonged interventions or those who have undergone surgery may lean towards a more medicalized narrative, compared to those who have accessed community support.

4.6.7 Ethnicity

All participants in this study are white, with the majority being white British. Thus, attempts to extrapolate the findings of this project to a wider range of ethnic groups should be done with caution. Norms with regards to body size differ cross-culturally (Brewis et al., 2011) and so we cannot assume that people of all cultures experience similar levels of weight stigma or have similar lived experiences with respect to their body size. It would also be pertinent to explore sub-cultural practice such as dietary practices as these will inevitably influence the lived experience of body size and weight loss interventions.

4.6.8 Gender

All the participants in this study were women. They were aged between 38 and 71. Due to the homogenous nature of the sample, it is not possible to assume that similar findings would be found amongst men or non-binary people. It is unclear why such a homogenous sample came forward and may relate to the demographic makeup of the OEN membership. Research has also found that in England, 76% of those undergoing bariatric surgery in 2014 were women (Desogus et al., 2019). As this study recruited people who have accessed NHS weight loss, this gender imbalance in undergoing bariatric surgery, may be reflected in who came forward for the study.

Future research should focus on the experiences of men whose voices were absent from this project.

Examining the lived experiences of trans people of living with obesity may be a particularly interesting study as trans people experience significant medicalision in relation to their gender identity. The intersections of this with obesity may help to illuminate further the impacts of medicalisation on peoples' lived experiences.

4.7 Reflexivity

To ensure a good standard of qualitative research, reflexivity is vital. Smith and Osborne, (2015) highlight that IPA requires the researcher to make sense of the participant making sense of their world. Therefore, it is inevitable that the researcher's biases, assumptions, and values will influence the data. Reflexivity allows the researcher to engage with this and critically examine their contributions (Yardley, 2000). Reflexivity requires self-awareness and an acknowledgement that we are part of the social world and thus cannot adopt a lens of objectivity (Lambert et al., 2010).

Reflexivity has been divided into personal reflexivity and epistemological reflexivity (Willig, 2001). Personal reflexivity refers to how the researcher's values, ideologies and culture influences the research, as well as how the research may influence the researcher. Epistemological reflexivity refers to the assumptions we make about knowledge and knowledge production and how this shapes the research and its findings.

Giving myself time to engage reflexively with the data was important in how I approached this study. After interviews, I made time to think and reflect on the conversation. The transcription process allowed me to note questions I chose or directions I prioritised in conversations with people. This was helpful, as it encouraged me to think about how these decisions may have influenced the data, and whether anything might have been missed as a result. Part way through data collection I began a 6-month clinical placement in a Bariatric psychology team. This gave me a great insight into the issues faced by people accessing NHS weight loss services. It also helped to learn about how clinicians in the field engage with debates concerning obesity as a disease. It was interesting to reflect on not only the development of my knowledge of the area, but on how this then influenced my perspective on the data and its analysis. Having conversations with the field supervisor helped me to integrate new knowledge gained on placement and challenged me to think about how this might be informing my assumptions or approach to the study.

The process of completing the interviews, transcribing the data, and analysing it at times left me feeling that I was overly embedded in the material so that "I could not see the wood

from the trees". At these points I took breaks from the data, focusing on other tasks relevant to the project or made use of supervision meetings to gain some distance, by discussing it and having my ideas challenged.

I continued to engage reflexively with the data throughout the analysis stage. Keeping some personal notes and supervision conversations were particularly important. A challenge I experienced in the data analysis was a tendency to move into a more descriptive and cognitive way of considering participants' ideas regarding the obesity as a disease debate. I became aware that I was finding it more difficult to think about this through a phenomenological lens. Upon reflecting further, it was interesting to note that in the interviews where I asked participants about their ideas about this, something similar happened. Participants tended to move into a more abstract way of thinking that was generally removed from their lived experience. In my initial analysis of the data I had mirrored this and found it challenging to return to phenomenological frame. It was useful to reflect on this and I wondered how it had come about. Was it something about the debate itself that felt removed from peoples' experiences and needs? Was there something about how the question was framed in the interviews? This experience enabled me to consider more carefully the relational aspects of qualitative research and the construction of meaning as a two-way process. This further highlighted to me the need for critical engagement with methodology and findings, in addition to ensuring good quality control such as that outlined by (Yardley, 2000).

4.8 Conclusion

The current study presented an interpretative phenomenological analysis of how people who have accessed NHS weight loss services make sense of obesity. This study builds on previous work that suggests obese people internalise weight stigma, this has negative impacts on their health, relationships, and opportunities. This study also found that obesity can play a social function and that obese people are aware of expectations for them to behave in particular ways, these are embodied and often acted out relationally. Obese people internalise and contain other people's anxiety in relation to anxiety about control and body size which leads them to feel restricted in how they express themselves. Participants are clearly able to articulate their difficulties with weight; many spoke of

experiences and events that led to food and eating becoming problematic. However, the description of these experiences is often overshadowed by the intertwining of socially dominant conceptualisations of obesity, which make moral judgements about obese people and situate responsibility with individuals, rather than seeing it within a wider systems context.

The current study adds to the debate as to whether obesity should be designated as a disease in the UK. In highlighting the lived experience of those living with obesity this study demonstrated the harmful impact of weight stigma and the extent to which it is internalised. It showed that people living with obesity feel the need for their difficulties to be validated and understood.

There was a sense of ambivalence concerning disease designation and whether this could reduce weight stigma and discrimination based on body size. Some felt that disease designation may increase funding for treatment and research in obesity, but there was an overarching sense that it would do little to change the current state of play, particularly in relation to stigma. Disease designation was thought of in terms of sympathy or giving people an excuse not to take responsibility for their health. This demonstrated the power that ideas regarding personal responsibility hold with respect to the issue of personal responsibility.

This study demonstrates the valuable role that clinical psychology and qualitative research can bring to the issue of obesity. Psychologists are well placed to influence public understanding of obesity and policy development through multi-faceted understandings and public health interventions that target systems rather than individuals. Psychologists working in NHS weight loss services can make use of psychological interventions that allow for the exploration of the impacts of shame, dehumanisation, and discrimination. Finally, psychologists can and should advocate for those who experience weight stigma by using our position to amplify the voices of those who experience its effects. By challenging individualistic, blaming, and moralising accounts of obesity, psychologists can support changing the status-quo for people living with obesity.

CHAPTER 5: REFERENCES

Afzal, S., Tybjærg-Hansen, A., Jensen, G. B., & Nordestgaard, B. G. (2016). Change in Body Mass Index Associated with Lowest Mortality in Denmark, 1976-2013. *JAMA*, *315*(18), 1989–1996. https://doi.org/10.1001/jama.2016.4666

All Parliamentary Group on Obesity. (2019). *Tackling obesity is a shared responsibility for society.* Accessed on 01/04/2020. From: https://www.gov.uk/government/speeches/tackling-obesity-is-a-shared-responsibility-for-soci.

Ata, R. N., Thompson, J. K., Boepple, L., Marek, R. J., & Heinberg, L. J. (2017). Obesity as a disease: Effects on weight-biased attitudes and beliefs. *Stigma and Health*. 3(4), 406-416 https://doi.org/10.1037/sah0000087

Aune, D., Sen, A., Prasad, M., Norat, T., Janszky, I., Tonstad, S., Romundstad, P., & Vatten, L. J. (2016). BMI and all cause mortality: Systematic review and non-linear dose-response meta-analysis of 230 cohort studies with 3.74 million deaths among 30.3 million participants. *British Medical Journal*, *353*, i2156. https://doi.org/10.1136/bmj.i2156

Becker, J. C. (2010). Why Do Women Endorse Hostile and Benevolent Sexism? The Role of Salient Female Subtypes and Internalization of Sexist Contents. *Sex Roles*, *62*(7), 453–467. https://doi.org/10.1007/s11199-009-9707-4

Boero, N. (2007). All the News that's Fat to Print: The American "Obesity Epidemic" and the Media. *Qualitative Sociology*, *30*(1), 41–60. https://doi.org/10.1007/s11133-006-9010-4

Bombak, A. E., & Monaghan, L. F. (2017). Obesity, bodily change and health identities: A qualitative study of Canadian women. *Sociology of Health & Illness*, *39*(6), 923. https://doi.org/10.1111/1467-9566.12537

Black, C. (2016). *An Independent Review into the impact on employment outcomes of drug or alcohol addition, and obesity*. Retrieved From: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573891/employment-outcomes-of-drug-or-alcohol-addiction-and-obesity.pdf

Brandsma, L. L. (2005). Physician and Patient Attitudes Toward Obesity. *Eating Disorders*, *13*(2), 201–211. https://doi.org/10.1080/10640260590919134

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bray, G. A., Kim, K. K., Wilding, J. P. H., & on behalf of the World Obesity Federation. (2017). Obesity: A chronic relapsing progressive disease process. A position statement of the World Obesity Federation. *Obesity Reviews*, *18*(7), 715–723. https://doi.org/10.1111/obr.12551

Brewis, A. A., Wutich, A., Falletta-Cowden, A., & Rodriguez-Soto, I. (2011). Body Norms and Fat Stigma in Global Perspective. *Current Anthropology*, *52*(2), 269–276. https://doi.org/10.1086/659309

Brewis, A., Sturtz Sreetharan, C., & Wutich, A. (2018). Obesity stigma as a globalizing health challenge. *Globalization and Health*, *14*(1), 20. https://doi.org/10.1186/s12992-018-0337-x

British Obesity and Metabolic Society. (2019) *BOMSS Professional Standards and Commissioning Guidance*. Accessed on 19/01/2020 from: https://www.bomss.org.uk/guidelines/

British Psychological Society. (2019). *Psychological perspectives on obesity: Addressing policy, practice, and research priorities.* Accessed on 16/03/2020 from: https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/Psychological%20Perspectives%20on%20Obesity%20-%20Addressing%20Policy%2C%20Practice%2C%20and%20Research%20Priorities.pdf

Brownell, K. D., Kersh, R., Ludwig, D. S., Post, R. C., Puhl, R. M., Schwartz, M. B., & Willett, W. C. (2010). Personal Responsibility and Obesity: A Constructive Approach To A Controversial Issue. *Health Affairs*, *29*(3), 379–387. https://doi.org/10.1377/hlthaff.2009.0739

Carel, H. (2011). Phenomenology and its application in medicine. *Theoretical Medicine and Bioethics*, *32*(1), 33–46. https://doi.org/10.1007/s11017-010-9161-x

Carryer, J. (2001). Embodied largeness: A significant women's health issue. *Nursing Inquiry*, *8*(2), 90–97. https://doi.org/10.1046/j.1440-1800.2001.00094.x

Carter, S. K. (2010). Beyond control: Body and self in women's childbearing narratives. *Sociology of Health & Illness*, *32*(7), 993–1009. https://doi.org/10.1111/j.1467-9566.2010.01261.x

Charrow, A., & Yerramilli, D. (2018). Obesity as disease: Metaphysical and ethical considerations. *Ethics, Medicine and Public Health*, *7*, 74–81. https://doi.org/10.1016/j.jemep.2018.10.005

Conrad, P. (2005). The Shifting Engines of Medicalization. *Journal of Health and Social Behavior*, *46*(1), 3–14. https://doi.org/10.1177/002214650504600102

Contino, G. (2016). The Medicalization of Health and Shared Responsibility. *The New Bioethics*, *22*(1), 45–55.

Cooper, C. (1997). Can a Fat Woman Call Herself Disabled? *Disability & Society*, *12*(1), 31–42. https://doi.org/10.1080/09687599727443

Crossley, M. (1998). 'Sick Role' or 'Empowerment'? The Ambiguities of Life with an HIV Positive Diagnosis. *Sociology of Health & Illness*, *20*(4), 507–531. https://doi.org/10.1111/1467-9566.00113

da Luz, F. Q., Sainsbury, A., Mannan, H., Touyz, S., Mitchison, D., & Hay, P. (2017). Prevalence of obesity and comorbid eating disorder behaviors in South Australia from 1995 to 2015. *International Journal of Obesity*, *41*(7), 1148–1153. https://doi.org/10.1038/ijo.2017.79

da Silva, S. S. P., & da Costa Maia, Â. (2012). Obesity and Treatment Meanings in Bariatric Surgery Candidates: A Qualitative Study. *Obesity Surgery*, *22*(11), 1714–1722. https://doi.org/10.1007/s11695-012-0716-y

Danielsen, K. K., Sundgot-Borgen, J., & Rugseth, G. (2015). Severe Obesity and the Ambivalence of Attending Physical Activity: Exploring Lived Experiences. *Qualitative Health Research*, *26*(5), 685–696. https://doi.org/10.1177/1049732315596152

Davidson, J. (2001). Pregnant Pauses: Agoraphobic embodiment and the limits of (im)pregnability. *Gender, Place & Culture*, *8*(3), 283–297. https://doi.org/10.1080/09663690120067357

De Brún, A., McCarthy, M., McKenzie, K., & McGloin, A. (2014). Weight stigma and narrative resistance evident in online discussions of obesity. *Appetite*, *72*, 73–81. https://doi.org/10.1016/j.appet.2013.09.022

De Lorenzo, A., Gratteri, S., Gualtieri, P., Cammarano, A., Bertucci, P., & Di Renzo, L. (2019). Why primary obesity is a disease? *Journal of Translational Medicine*, *17*(1), 169. https://doi.org/10.1186/s12967-019-1919-y

Desogus, D., Menon, V., Singhal, R., & Oyebode, O. (2019). An Examination of Who Is Eligible and Who Is Receiving Bariatric Surgery in England: Secondary Analysis of the Health Survey for England Dataset. *Obesity Surgery*, *29*(10), 3246–3251. https://doi.org/10.1007/s11695-019-03977-3

Deurzen, E., van. (2014). *Structural Existential Analysis (SEA): A phenomenological research method for counselling psychology. Counselling Psychology Review, Vol. 29, No. 2, June 2014*

Disability Rights UK. (2018). Disability Benefit Spending Reduced by £5 billion over the last decade. Accessed on 2/02/2020 from https://www.disabilityrightsuk.org/news/2018/september/disability-benefit-spending-reduced-%C2%A35-billion-over-last-decade

Douglas, I. J., Bhaskaran, K., Batterham, R. L., & Smeeth, L. (2015). Bariatric Surgery in the United Kingdom: A Cohort Study of Weight Loss and Clinical Outcomes in Routine Clinical Care. *PLOS Medicine*, *12*(12), e1001925. https://doi.org/10.1371/journal.pmed.1001925

Douglas, S. J., & Michaels, M. W. (2004). *The mommy myth: The idealization of motherhood and how it has undermined all women.* (p. 382). Free Press.

Drewnowski, A., & Specter, S. (2004). Poverty and obesity: The role of energy density and energy costs. *The American Journal of Clinical Nutrition*, *79*(1), 6–16. https://doi.org/10.1093/ajcn/79.1.6

El-Sayed, A. M., Scarborough, P., & Galea, S. (2012). Unevenly distributed: A systematic review of the health literature about socioeconomic inequalities in adult obesity in

the United Kingdom. *BMC Public Health*, *12*(1), 18. https://doi.org/10.1186/1471-2458-12-18

Farrell, J., & Cacchioni, T. (2012). The Medicalization of Women's Sexual Pain. *Journal of Sex Research*, *49*(4), 328–336. Academic Search Complete.

Flegal, K. M. (2005). Commentary: The epidemic of obesity—What's in a name? *International Journal of Epidemiology*, *35*(1), 72–74. https://doi.org/10.1093/ije/dyi260

Furber, C. M., & McGowan, L. (2011). A qualitative study of the experiences of women who are obese and pregnant in the UK. *Midwifery*, *27*(4), 437–444. https://doi.org/10.1016/j.midw.2010.04.001

Ghanemi, A., & St-Amand, J. (2018). Redefining obesity toward classifying as a disease. *European Journal of Internal Medicine*, *55*, 20–22. https://doi.org/10.1016/j.ejim.2018.05.025

Goisis, A., Sacker, A., & Kelly, Y. (2015). Why are poorer children at higher risk of obesity and overweight? A UK cohort study. *European Journal of Public Health*, *26*(1), 7–13. https://doi.org/10.1093/eurpub/ckv219

Haga, B. M., Furnes, B., Dysvik, E., & Ueland, V. (2020). Putting life on hold: Lived experiences of people with obesity. *Scandinavian Journal of Caring Sciences*, *34*(2), 514–523. https://doi.org/10.1111/scs.12756

Hayes, N. (Ed.). (1997). *Doing qualitative analysis in psychology.* (pp. viii, 295). Psychology Press/Erlbaum (UK) Taylor & Francis.

Heavey, E. (2018). 'If I can walk that far': Space and embodiment in stories of illness and recovery. *Sociology of Health & Illness*, *40*(6), 1005–1018. https://doi.org/10.1111/1467-9566.12737

Horrigan-Kelly, M., Millar, M., & Dowling, M. (2016). Understanding the Key Tenets of Heidegger's Philosophy for Interpretive Phenomenological Research. *International Journal of Qualitative Methods*, *15*(1), 1609406916680634. https://doi.org/10.1177/1609406916680634

Hoyt, C. L., Burnette, J. L., & Auster-Gussman, L. (2014). "Obesity Is a Disease": Examining the Self-Regulatory Impact of This Public-Health Message. *Psychological Science*, *25*(4), 997–1002. https://doi.org/10.1177/0956797613516981

Jaacks, L. M., Vandevijvere, S., Pan, A., McGowan, C. J., Wallace, C., Imamura, F., Mozaffarian, D., Swinburn, B., & Ezzati, M. (2019). The obesity transition: Stages of the global epidemic. *The Lancet Diabetes & Endocrinology*, *7*(3), 231–240. https://doi.org/10.1016/S2213-8587(19)30026-9

Jackson, S. (2016). Obesity, Weight Stigma and Discrimination. J Obes Eat Disord 2:3. doi: 10.21767/2471-8203.100006

Jutel, A. (2006). The emergence of overweight as a disease entity: Measuring up normality. *Social Science & Medicine*, *63*(9), 2268–2276. https://doi.org/10.1016/j.socscimed.2006.05.028

Kanaya, A. M., Herrington, D., Vittinghoff, E., Ewing, S. K., Liu, K., Blaha, M. J., Dave, S. S., Qureshi, F., & Kandula, N. R. (2014). Understanding the high prevalence of diabetes in U.S. south Asians compared with four racial/ethnic groups: The MASALA and MESA studies. *Diabetes Care*, *37*(6), 1621–1628. PubMed. https://doi.org/10.2337/dc13-2656

Keaver, L., Pérez-Ferrer, C., Jaccard, A., & Webber, L. (2019). Future trends in social inequalities in obesity in England, Wales and Scotland. *Journal of Public Health*, *42*(1), e51–e57. https://doi.org/10.1093/pubmed/fdz022

Keaver, L., & Webber, L. (2016). Future trends in morbid obesity in England, Scotland, and Wales: A modelling projection study. *The Lancet*, *388*, S63–S63. https://doi.org/10.1016/S0140-6736(16)32299-1

Kyle, T. K., Dhurandhar, E. J., & Allison, D. B. (2016). Regarding Obesity as a Disease: Evolving Policies and Their Implications. *Endocrinology and Metabolism Clinics*, *45*(3), 511–520. https://doi.org/10.1016/j.ecl.2016.04.004

Lake, A., & Townshend, T. (2006). Obesogenic environments: Exploring the built and food environments. *Journal of the Royal Society for the Promotion of Health*, *126*(6), 262–267. https://doi.org/10.1177/1466424006070487

Lambert, C., Jomeen, J., & Mcsherry, W. (2010). Reflexivity: A review of the literature in the context of midwifery research. *British Journal of Midwifery*, *18*. https://doi.org/10.12968/bjom.2010.18.5.47872

Latner, J. D., & Stunkard, A. J. (2003). Getting Worse: The Stigmatization of Obese Children. *Obesity Research*, *11*(3), 452–456. https://doi.org/10.1038/oby.2003.61

Lebesco, K. (2011). Neoliberalism, public health, and the moral perils of fatness. *Critical Public Health*, *21*(2), 153–164. https://doi.org/10.1080/09581596.2010.529422

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, *4*(3), 324–327. PubMed. https://doi.org/10.4103/2249-4863.161306

Llewellyn, A., Simmonds, M., Owen, C. G., & Woolacott, N. (2016). Childhood obesity as a predictor of morbidity in adulthood: A systematic review and meta-analysis. *Obesity Reviews*, *17*(1), 56–67. https://doi.org/10.1111/obr.12316

McCullough, M. B. & Hardin, J. B. (2013). *Reconstructing Obesity: The Meaning of Measures and the Measure of Meaning*. *In Food, Nutrition, and Culture volume 2.* New York and Oxford, Berghann Books

McLeod, J. (2020). *Qualitative Research in Counselling and Psychotherapy*. https://doi.org/10.4135/9781849209663

Mehta, A., Marso, S. P., & Neeland, I. J. (2017). Liraglutide for weight management: A critical review of the evidence. *Obesity Science & Practice*, *3*(1), 3–14. PubMed. https://doi.org/10.1002/osp4.84

Merleau-Ponty, M. (1962). *Phenomenology of perception*. Routledge & Kegan Paul.

Merrill, E., & Grassley, J. (2008). Women's stories of their experiences as overweight patients. *Journal of Advanced Nursing*, *64*(2), 139–146. https://doi.org/10.1111/j.1365-2648.2008.04794.x

Moran, D. (1999). *Introduction to phenomenology*. Routledge.

Murray, S. (2008). *The "fat" female body*. Palgrave Macmillan.

National Institute for Health and Care Excellence. (2014). *Obesity: Identification, assessment, and management. Clinical Guidance.* Accessed on 21/01/2020 from: https://www.nice.org.uk/guidance/cg189

OECD. (2019). *The Heavy Burden of Obesity*. https://doi.org/10.1787/67450d67-en

Ogden, J., & Clementi, C. (2010). The Experience of Being Obese and the Many Consequences of Stigma. *Journal of Obesity*, *2010*, 429098. https://doi.org/10.1155/2010/429098

Office for National Statistics. (2020). Healthcare Expenditure; UK Health Accounts 2018. Accessed on 14/05/2020 from:

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/ukhealthaccounts/2018

O'Hara, L., & Gregg, J. (2006). The war on obesity: A social determinant of health. *Health Promotion Journal of Australia*, *17*(3), 260–263. https://doi.org/10.1071/HE06260

Orbach, Susie. (1989). *Fat is a feminist issue.... : How to lose weight permanently—Without dieting*. Arrow.

Parsons, T. (1964). *The social system*. Free Press.

Pearl, R. L., & Puhl, R. M. (2018). Weight bias internalization and health: A systematic review. *Obesity Reviews : An Official Journal of the International Association for the Study of Obesity*, *19*(8), 1141–1163. PubMed. https://doi.org/10.1111/obr.12701

Pearl, R. L., Puhl, R. M., Himmelstein, M. S., Pinto, A. M., & Foster, G. D. (2020). Weight Stigma and Weight-Related Health: Associations of Self-Report Measures Among Adults in Weight Management. *Annals of Behavioral Medicine*. https://doi.org/10.1093/abm/kaaa026

Peters, M. D. J., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D., & Soares, C. B. (2015). Guidance for conducting systematic scoping reviews. *International Journal of Evidence-Based Healthcare*, *13*(3). https://journals.lww.com/ijebh/Fulltext/2015/09000/Guidance_for_conducting_systematic_scoping_reviews.5.aspx

Pickett, K. E., Kelly, S., Brunner, E., Lobstein, T., & Wilkinson, R. G. (2005). Wider income gaps, wider waistbands? An ecological study of obesity and income inequality. *Journal of Epidemiology and Community Health*, *59*(8), 670. https://doi.org/10.1136/jech.2004.028795

Puhl, R., & Brownell, K. D. (2001). Bias, discrimination, and obesity. *Obesity Research*, *9*(12), 788.

Puhl, R. M., & Heuer, C. A. (2010). Obesity stigma: Important considerations for public health. *American Journal of Public Health*, *100*(6), 1019. https://doi.org/10.2105/AJPH.2009.159491

Puhl, R. M., Himmelstein, M. S., & Quinn, D. M. (2018). Internalizing Weight Stigma: Prevalence and Sociodemographic Considerations in US Adults. *Obesity*, *26*(1), 167–175. https://doi.org/10.1002/oby.22029

Puhl, R. M., & Liu, S. (2015). A national survey of public views about the classification of obesity as a disease. *Obesity*, *23*(6), 1288–1295. https://doi.org/10.1002/oby.21068

Puhl, R., & Suh, Y. (2015). Health Consequences of Weight Stigma: Implications for Obesity Prevention and Treatment. *Current Obesity Reports*, *4*(2), 182–190. https://doi.org/10.1007/s13679-015-0153-z

Public Health England. (2017). *Health Matters: Obesity and the Food Environment.* Accessed on 19/11/2019 from: https://publichealthmatters.blog.gov.uk/2017/03/31/health-matters-obesity-and-the-food-environment/

Ratcliffe, M. (2010). Depression, guilt, and emotional depth. *Inquiry,* 53: 6, 602 — 626. DOI: 10.1080/0020174X.2010.526324

Ratcliffe, D., & Ellison, N. (2015). Obesity and Internalized Weight Stigma: A Formulation Model for an Emerging Psychological Problem. *Behavioural and Cognitive Psychotherapy*, *43*(2), 239–252. Cambridge Core. https://doi.org/10.1017/S1352465813000763

Rogerson, D., Soltani, H., & Copeland, R. (2016). The weight-loss experience: A qualitative exploration. *BMC Public Health*, *16*, 371–371. PubMed. https://doi.org/10.1186/s12889-016-3045-

Rosen, H. (2014). Is Obesity A Disease or A Behavior Abnormality? Did the AMA Get It Right? *Missouri Medicine*, *111*(2), 104–108. PubMed.

Rosenberg, C. E. (2002). The tyranny of diagnosis: Specific entities and individual experience. *The Milbank Quarterly*, *80*(2), 237–260. PubMed. https://doi.org/10.1111/1468-0009.t01-1-00003

Royal College of Pediatrics and Child Health. (2017). *About Childhood Obesity*. Accessed on 01/04/2020 from: https://www.rcpch.ac.uk/key-topics/nutrition-obesity/about-childhood-obesity

Royal College of Physicians. (2018). *Obesity Should be Recognized as a Disease*. Accessed on 19/01/2019 from: https://www.rcplondon.ac.uk/file/11920/download

Schvey, N. A., Roberto, C. A., & White, M. A. (2013). Clinical correlates of the Weight Bias Internalization Scale in overweight adults with binge and purge behaviours. *Advances in Eating Disorders*, *1*(3), 213–223. https://doi.org/10.1080/21662630.2013.794523

Shinebourne, P. (2011). The theoretical underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis*, *22*(1), 16–31.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*(1), 39–54.

Smith, J. A., & Eatough, V. (2007). Interpretative phenomenological analysis. *Analysing Qualitative Data in Psychology.*, 35–50. https://doi.org/10.4135/9781446207536.d10

Smith, J. A., & Osborn, M. (2003). *Interpretative phenomenological analysis.* In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (p. 51–80). Sage Publications, Inc.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain*, *9*(1), 41–42. PubMed. https://doi.org/10.1177/2049463714541642

Smith, J. A., & Shinebourne, P. (2012). Interpretative phenomenological analysis. *APA Handbook of Research Methods in Psychology, Vol 2: Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological.*, 73–82. https://doi.org/10.1037/13620-005

Swinburn, B., Egger, G., & Raza, F. (1999). Dissecting Obesogenic Environments: The Development and Application of a Framework for Identifying and Prioritizing Environmental Interventions for Obesity. *Preventive Medicine*, *29*(6), 563–570. https://doi.org/10.1006/pmed.1999.0585

The Lancet Diabetes & Endocrinology. (2017). Should we officially recognise obesity as a disease? *The Lancet Diabetes & Endocrinology*, *5*(7), 483. https://doi.org/10.1016/S2213-8587(17)30191-2

Thibodeau, P. H., Perko, V. L., & Flusberg, S. J. (2015). The relationship between narrative classification of obesity and support for public policy interventions. *Social Science & Medicine*, *141*, 27–35. https://doi.org/10.1016/j.socscimed.2015.07.023

Thomas, S. L., Hyde, J., Karunaratne, A., Herbert, D., & Komesaroff, P. A. (2008). Being "fat" in today's world: A qualitative study of the lived experiences of people with obesity in Australia. *Health Expectations: An International Journal of Public Participation in*

Health Care & Health Policy, *11*(4), 321–330. https://doi.org/10.1111/j.1369-7625.2008.00490.x

Tischner, I. (2012). Fat lives: A feminist psychological exploration. *Fat Lives: A Feminist Psychological Exploration*, 1–166. https://doi.org/10.4324/9780203079898

Tomiyama, A. J. (2014). Weight stigma is stressful. A review of evidence for the Cyclic Obesity/Weight-Based Stigma model. *Appetite*, *82*, 8–15. https://doi.org/10.1016/j.appet.2014.06.108

Tomiyama, A. J., Carr, D., Granberg, E. M., Major, B., Robinson, E., Sutin, A. R., & Brewis, A. (2018). How and why weight stigma drives the obesity 'epidemic' and harms health. *BMC Medicine*, *16*(1), 123. https://doi.org/10.1186/s12916-018-1116-5

Ueland, V., Furnes, B., Dysvik, E., & Rørtveit, K. (2019). Living with obesity—Existential experiences. *International Journal of Qualitative Studies on Health and Well-Being*, *14*(1), 1651171. https://doi.org/10.1080/17482631.2019.1651171

van Dijk, W., Faber, M. J., Tanke, M. A. C., Jeurissen, P. P. T., & Westert, G. P. (2016). Medicalisation and Overdiagnosis: What Society Does to Medicine. *International Journal of Health Policy and Management*, *5*(11), 619–622. PubMed. https://doi.org/10.15171/ijhpm.2016.121

Vigarello, G. (2013). *The Metamorphoses of Fat: A History of Obesity*. New York, Columbia Press

Watson, P., Wiers, R. W., Hommel, B., Ridderinkhof, K. R., & de Wit, S. (2016). An associative account of how the obesogenic environment biases adolescents' food choices. *Appetite*, *96*(C), 560–571. https://doi.org/10.1016/j.appet.2015.10.008

Webb, H. (2009). 'I've put weight on cos I've bin inactive, cos I've 'ad me knee done': Moral work in the obesity clinic. *Sociology of Health & Illness*, *31*(6), 854–871. https://doi.org/10.1111/j.1467-9566.2009.01188.x

Westland, S. (2016). *Being large: an interpretative phenomenological enquiry into the lived world of problematic weight.* Unpublished doctoral thesis. Middlesex University, England.

Wilding, J. P. H., Mooney, V., & Pile, R. (2019). Should obesity be recognised as a disease? *BMJ*, *366*, l4258. https://doi.org/10.1136/bmj.l4258

Williams, O., & Annandale, E. (2018). Obesity, stigma, and reflexive embodiment: Feeling the 'weight' of expectation. *Health*, 1363459318812007. https://doi.org/10.1177/1363459318812007

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Open University Press. https://books.google.co.uk/books?id=ejVsQgAACAAJ

Willig, C. & Stainton-Rogers, W. (2008). The Sage Handbook of Qualitative Research in Psychology. London: Sage

World Health Organization. (2020). *Obesity and Overweight: Key Facts.* Accessed on 28/04/2020 from: https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, *15*(2), 215–228. https://doi.org/10.1080/08870440008400302

Żukiewicz-Sobczak, W., Wróblewska, P., Zwoliński, J., Chmielewska-Badora, J., Adamczuk, P., Krasowska, E., Zagórski, J., Oniszczuk, A., Piątek, J., & Silny, W. (2014). Obesity and poverty paradox in developed countries. *Annals of Agricultural and Environmental Medicine*, *21*(3), 590–594. https://doi.org/10.5604/12321966.1120608

CHAPTER 6: APPENDECES

Appendix A: Search Key words

Rationale	**Data Base**	**Search Terms**
Understanding current debates regarding obesity conceptualization and medicalization.	Psych Info Psych Articles CINHAL Scopus Academic Search Complete Google Scholar	"Obesity" AND "Disease" (title only) "Obesity" AND "Disease designation" "Obesity" AND "Medicalization" "Obesity" AND "Conceptulization" "Obesity" AND "Pathologization" "Obesity" AND "making sense" "Fat" AND "Medicalization" "National Health Service" AND "Obesity". "Obesity" AND "Blame"
The experience of living in a larger body. Embodiment and internalization of obesity and obesity stigma.		"Obesity" AND "Shame" "Weight Stigma" AND "Internalisation" "Obesity" AND "Embodiment". "Fat Shaming"

Inclusion criteria

Adults, aged 18+

Studies engaging with conceptualizations and debates on obesity

Studies examining weight stigma

Studies examining the lived experience/phenomenology of obesity

Exclusion criteria

Studies conducted with children

Medical and surgical articles

Journals not written in English

Appendix B: Permission to recruit through OEN

DJ

Thu 31/01, 09:27

Claire HENRY

Inbox

Dear Claire,
The steering group of OEN have no objections to approaching our membership.
I am in London on Tuesdays and Thursdays. If that doesn't suit we could talk on the phone?

Dr Jackie Doyle
Clinical Psychologist

Appendix C: Interview Schedule and Prompts

Opening Questions:

Name:

Age:

Ethnicity:

Weight Loss services accessed:

When:

The questions below identify the types of questions that will be explored during the semi-structured interview.

Questions will be asked to identify what type of services participants have accessed. For example:

1. What type of NHS weight loss services have you accessed in the past/or are you currently accessing? What has your experience of this been? Examples might include GP, medication, community services, surgery.
2. Have you accessed any private weight loss services? What has your experience been? Examples may include, Weight watchers, slimming world, alternative approaches.

Questions that focus on a person's history with weight and obesity will be explored, examples include:

1. How old were you when you first identified weight as an issue?
2. What ideas do you have about why weight has been a difficulty for you?
3. Do you associate weight loss or weight gain with any particular issues/events/time periods in your life?
4. What emotions do you associate with changes to your weight? Wellness associated with higher and lower weight.

Questions that focus on peoples' embodiment of weight will be asked. Part of this study aims to explore how people make sense of themselves, others, and relationships through their embodiment of obesity. Examples include:

1. Do you think there are things in your life that you do not do, or choose not to do because of your weight, for example, in your social life, work life, intimacy? Has this changed with weight loss or gain? Presentation, clothing, interaction.

2. If you have experienced any weight changes (loss or gain), has this impacted on your relationships? If so, how?

Questions that explore how people consider the disease conceptualisation of obesity in relation to their experience will be explored. Examples include:

1. Have you heard about the idea of officially calling obesity a disease? If so, what do you think about this?
2. What does disease mean to you?
3. How do you think calling obesity a disease might influence your experience of a. day-to-day life, b. engagement with services, c. relationships, d. anything else?

Meaning of Obesity as a disease to that person. What impact it may have on others and/or relationships with others. How might it positively or negatively change some of the experiences already discussed?

1. What do you imagine the impact would be on general population? Health professionals?

The emotional content of participants' experience will be attended to and space to explore different areas will be provided. The questions provided are intended as examples as it is hoped that different questions will be a springboard from which issues can be elaborated and explored as/if they are relevant to each participant.

Appendix D: Recruitment poster

Is obesity a disease?

Increasingly there is a move in several countries to officially classify obesity as a disease. A similar debate is currently underway, in the United Kingdom. I am seeking participants for interviews to explore and discuss this idea and how it relates to people's own experiences of obesity.

Interviews will be approximately one hour in duration and take place either at the University of East London or another location that may be more convenient for you.

You can take part if you:

- Are over the age of 18.
- Are currently or have in the past accessed an NHS weight loss service, for example, weight loss support through your GP, bariatric surgery.

This study 'How do people who access NHS weight loss services conceptualise obesity' is being undertaken as part of the fulfilment of my Doctorate in Clinical Psychology at the University of East London. If you would like more information or are interested in taking part, please contact Claire Henry on

U1221800@uel.ac.uk

*You have received this invitation because you have signed up to the Obesity Empowerment Network mailing list. If you do not wish to receive any more notices regarding this study, please reply to this email to let us know.

Appendix E: Participant Information Letter

University of East London

Stratford Campus

Water Lane

London E15 4LZ

Participant Information Letter

Principal Investigator: Claire Henry, Trainee Clinical Psychologist

Contact: u1221800@uel.ac.uk

Consent to participant in a research study

The purpose of this letter is to provide you with the information you need to decide whether you wish to participate in this research project. This project forms part of my Professional Doctorate in Clinical Psychology degree.

Project title

How do people who access NHS weight loss services conceptualise obesity?

Project description?

The aim of this project is to understand how people who access NHS weight loss services conceptualise and think about obesity. There are currently many ways in which obesity is

spoken about in health services, the media and individuals. Recently, there has been a move in several countries, for example, USA, Israel to officially call obesity a disease. This has important implications for the way in which services are provided to people. Some studies have examined ways that people make sense of and experience their weight, however, further research needs to be conducted with people who use NHS weight loss services. It is hoped that this project will be a valuable addition to the national conversation around obesity.

Participating in the project

If you decide that you would like to take part in this project, you will be invited to attend a face to face meeting with the principal investigator at a convenient location. It is expected that the interview will take approximately one hour. You will be asked some questions to guide the discussion, but there is not a strict agenda as the aim of the project is to get an understanding of your views and ideas. You are very welcome to see the interview questions prior to the interview.

Your participation in the project is entirely voluntary. If you decide to take part, you can change your mind and withdraw your data from the study at any point up until 1st February 2020 by contacting the principal investigator using the details above. This date has been chosen as a cut off as it is expected that the project will be finalised shortly after this date. Before starting the interview, I will ask you if you are happy to continue and you will be asked to sign a consent form.

Use of information

You will be asked to provide some details about yourself, including your name, age, gender, location and contact information. You will also be asked about what NHS weight loss services you have accessed in the past or are currently accessing. The interviews will be recorded and stored securely (i.e. password protected). Shortly after the interviews, the recordings will be transcribed and anonymised. The principal investigator and project supervisor (a member of staff at the University of East London) only will be able to access recorded interviews or interview transcripts. The recordings will be kept until they are no longer required for university approval (by September 2020). Anonymised transcripts may be kept for several years as it is hoped that this study will be published in an academic journal.

Once the recordings have been transcribed the data will be analysed using a qualitative research method. The findings will then be written up and presented as a doctoral thesis. The project will be publicly available on ROAR- a website that publishes research work completed by students at the university of East London. Findings may be presented relevant conferences and meetings and will be published in an academic journal.

Confidentiality

Your personal details will be confidential and not disclosed to others. The only exception to this is if any concerns about your safety or the safety of others is raised. In this case I may be required to share information with others who may be able to help or who may need to know. If concerns about your safety or that of someone else were raised I would initially seek advise from my supervisor. If we felt that we needed to break confidentiality every effort would be made to inform and involve you.

Are there any risks in taking part?

It is not envisioned that taking part in this study will cause any risk of harm to you and it is hoped that you will enjoy taking part in the project. However, we do understand that speaking about personal experiences or difficulties can, at times be distressing. If you do experience distress as a result of taking part in the project, I would be happy for you to get in contact with me. I am unable to offer your any counselling or therapy; however, I would be happy to think with you about what or who might be able to help. If I notice that you become distressed during the interview, I may contact you to check in after the interview.

Please feel free to ask me any questions about the project.

If you are happy to continue you will be asked to sign a consent form prior to your participation.

Please retain this invitation letter for reference. If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [X, School of Psychology, University of East London, Water Lane, London E15 4LZ.X.X] or Chair of the School of Psychology Research Ethics Sub-committee: X, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: X. Email: X@uel.ac.uk)

Thank you,

Yours sincerely,

Claire Henry

Appendix F: Participant consent form

University of East London

Stratford Campus

Water Lane

London E15 4LZ

Participant consent form

Study Title

How do people who access NHS weight loss services conceptualise obesity?

I have read and understood the information letter and have been given a copy to keep. ☐

I have been given the opportunity to discuss the details of the study and ask questions. ☐

I understand that my information will be kept confidential and that only the researchers involved in the study will have access to my information ☐

I hereby freely and fully consent to participate in the study which has been fully explained to me. ☐

I understand that I am free to withdraw my consent to participate in this project until 1st February 2020 without being obliged to provide a reason. ☐

I understand that the research findings may be published at a later date.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: ……..

Appendix G: De-brief form

University of East London

Stratford Campus

Water Lane

London E15 4LZ

Dear Participant,

Thank you for your involvement in this study. This study aims to understand how people who access NHS weight loss services make sense of obesity. Your contribution is valuable as it is hoped that this study will contribute to the national conversation about obesity and the current debates about whether it should be labelled as a disease.

Your data will be securely held and once the interviews have been transcribed, your data will be anonymised. You can withdraw your consent to partake in this study up until the 1st February 2020.

It is not anticipated that your participation will cause you any distress, however, we recognise that sometimes speaking about personal and sensitive topics can cause be upsetting. If you feel that you need some support following your participation in this study I would suggest contacting any of the organisations detailed below.

While I cannot provide emotional support, I would be very happy to talk through the support options listed, if you would like to do this please feel free to contact me on the details below.

Support Organisations

NHS Direct: Phone 111 (24 hours a day, 7 days a week)

Samaritans: Phone or text 116 123 (24 hours a day, 7 days a week)

SANEline 0300 304 7000 (4.30pm to 10.30pm, 7 days a week).

Thank-you again for your participation.

Kind Regards,

Claire Henry

Trainee Clinical Psychologist

U1221800@uel.ac.uk

Appendix G: Ethical Approval Confirmation

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Miha Constantinescu

SUPERVISOR: **Kenneth Gannon**

STUDENT: Claire Henry

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: How do people who access NHS weight loss services make sense of obesity?

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

1. APPROVED

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data. Student's name *(Typed name to act as signature):* Student number: Date: *(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐

MEDIUM (Please approve but with appropriate recommendations)

[X] LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Dr Miha Constantinescu

Date: 8.04.2019

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of

the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix H: Approved data management plan

UEL Data Management Plan: Lite

For PGRs to submit to PhD Manager prior to Examination

This 'lite' DMP is written at project completion stating what will happen to your research data: if you already have a DMP from earlier in your project you do not need to complete this form.

Plans must be sent to researchdata@uel.ac.uk for review.

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs.

Administrative Data		
Researcher	Name: Claire Henry	
	Email: u1221800@uel.ac.uk	ORCiD:
Research title and description	How do people who access NHS weight loss services make sense of obesity? The research question for this project is 'How do people who access NHS weight loss services make sense of obesity?' The aim of the research is to explore discourses and experiences that people who identify as overweight or obese draw from to make sense of weight. The proposed research study will examine the current movement towards the designation of obesity as a disease and how this features in participants' accounts.	
Research Duration dd/mm/yy	Start date: 01/04/2019	End date: 01/12/2020
Ethics application reference	N/A Ethical Approval received from the School of Psychology	

<table>
<tr><td>Funder</td><td colspan="2">N/A Part of the Professional Doctorate in Clinical Psychology</td></tr>
<tr><td>Date of DMP</td><td>First version: 18/01/2019</td><td>Last update:</td></tr>
<tr><td>Related Policies</td><td colspan="2">e.g. Research Data Management Policy</td></tr>
<tr><td>About your Data</td><td colspan="2"></td></tr>
<tr><td>What data have you collected and where is it stored?</td><td colspan="2">
<table>
<tr><th>Data type</th><th>Format</th><th>Volume</th><th>Storage location</th><th>Back up location</th></tr>
<tr><td>Anonymised transcripts</td><td>.docx</td><td>50MB</td><td>Password protected folder on laptop</td><td>Encrypted memory stick</td></tr>
<tr><td>Participant consent forms</td><td></td><td></td><td>H:drive</td><td></td></tr>
<tr><td>Interview audio recordings</td><td></td><td></td><td>UEL One drive</td><td></td></tr>
</table>
Which data (if any) is personal or sensitive?

Data collected in the course of the qualitative interviews regarding peoples' engagement with NHS weight loss services and their personal and relational experiences of obesity is likely to be sensitive.
</td></tr>
<tr><td>Documentation and Metadata</td><td colspan="2"></td></tr>
<tr><td>What documentation and metadata accompanies the data?</td><td colspan="2">Participant information sheets, consent forms, list of guide interview questions and debrief sheet. Audio files and transcripts of interviews.</td></tr>
<tr><td>Data Sharing</td><td colspan="2"></td></tr>
</table>

Other researchers may be interested in your data: can you share on UEL's repository?	Anonymised transcripts will be shared with the research supervisor via UEL email. File names will be participant numbers e.g. Participant 1. Extracts of transcripts will be provided in the final research and any subsequent publications. Identifiable information will not be included in these extracts. Anonymised transcripts will not be deposited via the UEL Repository in order to protect anonymity.
Data Retention	
Which data are of long-term value and should be kept?	Signed consent forms will be held on UEL H: drive until the thesis has been completed and passed and any publications submitted. After this they will be deleted. Audio recordings will be deleted upon completion of the thesis. Interview transcripts will be retained on an encrypted memory stick held at the researcher's private property.
Review	**Please send your plan to researchdata@uel.ac.uk**
Date: 26/02/2020	**Reviewer name: Penny Jackson** **Research Data Management Officer**

Appendix I: Written notation on transcripts

Three examples from different transcripts are provided.

too much. So, I made up a stupid excuse as to why I couldn't eat carbs. So, that would cut out a big bulk of the food. Then I'd perhaps order a salmon fillet and salad. And I can't eat the salad because it's too much. But, even that sometimes was too much. So, I'd chop it up into little bits and hide it under the salad [laughs] and push it around the plate and just pretend to take absolutely ages and engage in sparkling conversation, so that they ate all theirs and they thought I'd eaten the same amount, when really I'd only eaten a little bit. So, I because very skilled at pretending to eat the same as everyone else, when really I'd eaten nothing.

I: Mm- were you worried about how they would react?

P: Yeah, I was -um- worried that they would judge me as, I don't know what, judge me badly. I don't know what I thought they would judge me as. But, I didn't feel confident enough to say: "Ah, I had weight loss surgery last year Yeah, I was twenty stone and now I'm only ten.". I just didn't feel confident and I felt it was -um- I think I felt they would think the person in front of them was a lie and really I was a fat person disguised as a thin person for tonight [laughs].

I: And what would it mean to be a fat person disguised as a thin person, do you think?

P: -Mm- well I don't know. I think that people do react differently to fat people in a negative way than they do to thin people. It's definitely a thing. I have had so much more attention being slim, than I ever did being fat.

I: Do you mean, like, good attention?

P: Positive attention and attention from men. Oh my god, I'm like just ridiculous the amount of men than give me attention. I could go on dates endlessly, it's not a problem. But, when you're fatter that is an issue. And there is only a certain sector of society that will tolerate fat people. People are very judgemental. They think that you are a bad person, because you're fat. Or a horrible person, or a slovenly person. You know, all the words that go with negativity go with fat people. They judge, they just judge negatively.

I: Yeah, because this is something that comes up. I mean what ideas do you have about why it's so negative, compared to other aspects of people and differences between people?

about the weight, I really wanted to lose the weight. So I bought diet pills off the internet, bad idea.

Interviewer: *What happened?*

Participant 3: Well, nothing so much happened, but I lost 6 pounds.

Interviewer: *mm*

Participant 3: But then, it was unsustainable, I couldn't carry it on. So, I put three back on. And between looking at the price and looking at what was in these pills, it was stupid, I thought, you need to get help, you can't do this on your own. Because that was my mantra all the way through, I was going to do this on my own. I put the weight on on my own, I can get it off on my own.

Interviewer: *It sounds like the idea of doing it on your own was important to you?*

Participant 3: It was, because it was my way of proving to everybody, and by everybody I don't mean my husband and children, but I mean, proving to everybody that I could do it. And that I wasn't some lazy silly person that just (inaudible), although I must admit I did when I first gave up smoking, that didn't help with putting the weight on, but after that and when I'd gotten over the cravings of that initial thing, then after that I managed to curb my eating. But, I wanted to prove to everybody that I could do it, because I just felt that I was coasting along and it was all out of control and everything was just happening, and this is something that I could control.

Interviewer: *do you think that people felt that it was really up to you to do this and that you weren't putting in the work, or was it..*

Participant 3: Yeah! I mean I felt very judged.

Interviewer: *Right..*

Participant 3: whether deliberately or not, or whether it was all in my mind, I felt very judged, even by my parents, they were very judgemental.

Interviewer: *and how did they, how did that come up? Was it comments, was it the way people behaved towards you, how did you notice it?*

Participant 3: It was looks, it was their attitude towards me, nothing was ever said and mum was always encouraging if I start[illegible] new diet, and she would go around and say something silly like, if I had s[illegible]

Appendix J: List of Codes

Conflicting Coneptualisations
Ambivalence about disease label
Can't find understanding professionals
Compare to others whose behaviour is deemed problematic
Disease label an excuse
Disease radical public policy needed
Disease V Choice
Education is the answer
Expectations of weight loss surgery high
Exposing
Food as good or bad
Health issues not taken seriously when overweight. All health is attributed to weight
Healthy resources inaccessible
Idea that obeese people refuse to comply with medical advise
Individual is at fault for being fat
Individuals feel that they must educate healthcare professionals about obesity
IT IS person's responsibility change or conflict in narrative
Medicalized
Neo-liberal ideology
No empathy for others despite own experience
Obesity as a disability
Prove you are worthy of care
Social function of fat and medicalization
Abuse towards obese people is socially acceptable

Adopt negative attitudes
Battle of dealing with stigma
Betray self to be acceptable
Being fat is viewed as a moral failing
Cared for in spite of weight
Control or loss of control
Fat stigma is inescapable
Fear of Fat
Humiliation
Internalised judgment
Lose weight for others
Managing how others construct your identity
Morality
Not deserving of treatment on NHS own responsibility
Not telling people about surgery
Obesity individualised despite research to the contrary
Objectified and commodified
Othering as a social defense
Passive
People project their own feelings of low self-worth and poor body image
Public will not accept disease label
Punishment as motivation
Responsibility with individual
Restricted
Scapegoat

Seen as equally stigmatised in both genders
Simplistic understandings of weight loss from health care professionals
Slimness is success
Social exclusion thorough social infrastructure
Views of obesity are inflexible
Uncertainty about what disease label means
Understanding self and why weight is an issue
Differentiated
Disease label as defense against blame
Disease label could change conceptualisation of obesity treatment
Disease label could increase access to treatment
Disease label will not increase public sympathy or understanding
Disease label reduce stigma increase understanding
Dismissed
Exclusion
Fat as Identity and the Embodiment of obesity
Anger
Be good to deserve help
Be invisible or minimise self
Dehumanised
De-sexualised
Embodied disgust
Embodiment and mental health
Embodiment and monitoring
Embodiment exclude self

Extreme or obsessed
Fat as a representation of the self
Fat as a feeling
Fat body is publically owned
Fat embodiment- relate differently
Fat makes you a bad person
Fat people are seen as lazy and stupid
Fat person is offensive to others
Identity or persona creation
Infantalized
Life marked by weight
Life wasted or less enjoyable
Lonely
Your worth as a person is defined by your weight
Isolation
Precise weight is clearly remembered
Shame
Trauma and Distress Implicit
Clear memory of early distressing memory around weight
Distress and trauma implied and linked to eating
Early trauma linked to weight gain
Food as addiction
Mental health cost of weight stigma
More psychological support needed
Pain and trauma of fat stigma

Protect and shield self is important
Psychological costs of dieting
Rare to be supported and not blamed
Rebellion or survival
Resistance
Sacrifice to reduce weight
Silenced, experience not taken seriously
Social withdrawal
Survival through food
Teach children to ignore their bodily cues
Trigger or life change understood as trigger for weight gain
Understanding that obesity is complex
Validation needed
Weight problematized early in life

Appendix K: Examples of coded text

Code	**Extract**
Shame	For me, my weight is a huge sense- and it has been my entire life- a huge sense of guilt and shame. (Shannon) So, I think we all have a trigger. The difference is, you can see mine. And I don't mean that you can see that I'm in a restaurant and I'm trying to debate what to eat and I'm googling the calories, or whatever. It's the fact that whether I'm a size twelve and in my head I'm still a size twenty-eight. Or I'm sitting there, literally a size twenty-eight. You can see my inner shame in a way that someone is a daily alcoholic or a chain smoker or who was a kleptomaniac or a shop lifter, you can't see all of that. (Rachel)
Trigger or life change understood as trigger for weight gain.	When I was six; I had my tonsils removed. Up to that point I'd been a lively kid that couldn't stop, was always running around. Had my tonsils out and I presume it's the anti-biotics, for years I assumed it was the surgery that flipped a switch. (Jenny)
Survival through food	I mean just ironically when my parents were in the process- when the marriage was breaking down. I remember really vividly one evening when they'd had a very verbal argument and things were very heated. So, my dad had rung his parents; my grandparents to come over because things were really stressful. So, the first thing my granddad says is: "Should we go out to KFC?". It's very much that from that age; food is the solution, isn't it? And we'll distract you with a bucket of fried chicken. (Tina)

Disease label will not increase public sympathy	I don't think there is much sympathy in the population. People will think—and I know there are people who are on a medication that makes them put on weight, and every sympathy to them. But, if we go for the majority, I think most people don't have sympathy for seeing someone overweight, eating a box of chips and then saying: "I've got a disease".